2025 PEBB Continuation Coverage (COBRA) Election/Change

HCA | Health Care Authority
Public Employees Benefits Board

Clear form

We must receive this form **no later than 60 days** from the date your PEBB health plan coverage ends or from the postmark date on the *PEBB Continuation Coverage Election Notice* sent to you, whichever is later.

Your first premium payment and applicable premium surcharges are due to the Health Care Authority (HCA) **no later than 45 days** after your 60-day election period ends. We will not enroll you until we receive your first payment. If HCA does not receive your first payment before the end of this 45-day timeframe, you will not be enrolled, and you will lose your rights for PEBB Continuation Coverage (COBRA). Premiums and applicable premium surcharges are due from the date your other coverage ended.

This form replaces all *PEBB Continuation Coverage (COBRA) Election/Change* forms previously submitted. You must complete the entire form, including the dependent section for any children you want to continue to cover.

Inaccurate, incomplete, or illegible information may delay coverage. Type or print clearly in dark ink and use all capital lettering in the spaces provided. Example: J O H N

All forms and documents are available on HCA's website at **hca.wa.gov/pebb-continuation** under *Forms & publications* or by calling 1-800-200-1004 (TRS: 711).

⚠ Remember to read and sign Section 8.

Employee or retiree (subscriber) information only

Last name

First name

Social Security number

Date PEBB health plan coverage ended

1 Subscriber

If you are enrolled in Medicare, this information needs to match your Medicare records to avoid delays in coverage starting.

Social Security number

Date of birth

Sex assigned at birth[1]
☐ Male ☐ Female

Last name

Gender identity[2]
☐ Male ☐ Female ☐ X

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address

Address line 2

City

State

ZIP/Postal code

County

1 This field is required for health care services.

2 Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit **hca.wa.gov/gender-x**.

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Subscriber's last name

Social Security number

Mailing address (if different)

Mailing address line 2

City

State

ZIP/Postal code

County

⚠ You must report your new address to the PEBB Program **no later than 60 days** after you move. You can report it by using this form, sending a written request by mail or secure message (see "Form return" on page 13), or calling 1-800-200-1004 (TRS: 711).

Are you or any eligible dependents enrolled in PEBB insurance coverage under another account? Yes No

Continue coverage (Select all that apply.)

- Medical
- Dental
- Vision

Add coverage (Select all that apply.)

- Medical
- Dental
- Vision

Terminate coverage (Select all that apply.)

- Medical
- Dental
- Vision

Termination date:

⚠ You may elect to continue coverage you were enrolled in on the day your PEBB health plan coverage ended. If you have PEBB life insurance you wish to port or convert, call MetLife at 1-866-548-7139.

If you are enrolled in a flexible spending arrangement (FSA) or a Limited Purpose FSA and would like to continue it, call Navia Benefit Solutions at 1-800-669-3539. Navia must receive your request **no later than 60 days** from the date your PEBB health plan coverage ended, or from the postmark date on the *Navia COBRA election notice* sent to you, whichever is later.

If terminating coverage, include reason:

⚠ If you terminate all coverage, you will not be eligible to enroll again in PEBB Continuation Coverage unless you regain eligibility.

Do you receive Social Security Disability? Yes No If Yes, effective date

If Yes, attach a copy of your Social Security Disability Award letter. Write your full name and the last four digits of your Social Security number on the copy. You and your enrolled dependents may be eligible for additional months of coverage.

Subscriber's last name

Social Security number

Are you enrolled in Medicare Part A or Part B?

Part A (hospital)

Yes No If Yes, enter effective dates shown on your Medicare card:

Part B (medical)

Yes No If Yes, enter effective dates shown on your Medicare card:

Medicare number

If Yes, proof is required. Attach a copy of your Medicare benefit verification letter or a copy of your Medicare card to this form. Write your full name and the last four digits of your Social Security number on the copy. You could face penalties if you don't enroll in Medicare Part A and Part B when you become eligible. Federal rules do not allow you to waive Medicare while on COBRA coverage. **You will not be enrolled until your proof of Medicare is received.**

⚠ Premium surcharges do not apply to subscribers who are enrolled in Medicare Part A and Part B.

Tobacco use premium surcharge

Response required if you are enrolling in medical coverage. The PEBB Program requires a $25-per-account tobacco use premium surcharge in addition to your monthly medical premium if you or a dependent (age 13 or older) enrolled on your PEBB medical plan uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. Visit HCA's website at **hca.wa.gov/pebb-continuation** for more information.

Does the tobacco use premium surcharge apply to you? Check one:

No, I am enrolled in Medicare Part A and Part B. The premium surcharge does not apply.

Yes, I am subject to the $25 premium surcharge. I have used tobacco products in the past two months. (If this is a change to a previous attestation, indicate the date your tobacco use changed.)

Date of change:

No, I am not subject to the $25 premium surcharge. I have not used tobacco products in the past two months, or I have enrolled in or accessed one of the tobacco cessation resources noted on HCA's website.

Subscriber's last name

Social Security number

2 Spouse or state-registered domestic partner (SRDP)

If enrolling or removing a spouse or SRDP, complete this section. If not, skip to Section 3.

List an eligible spouse or SRDP you wish to cover or remove from coverage. SRDP is defined in WAC 182-12-109. State-registered domestic partnerships include partners of legal unions from another jurisdiction that is substantially equivalent to a domestic partnership in Washington State. Individuals in state-registered domestic partnerships are treated the same as legal spouses except when in conflict with federal law. You must also provide proof of their eligibility within the PEBB Program's enrollment timelines, or they will not be enrolled. Timelines and a list of documents we will accept to prove eligibility are available on HCA's website at **hca.wa.gov/pebb-continuation**.

Your spouse or SRDP cannot be enrolled in two PEBB medical, dental, or vision accounts at the same time.

If enrolling an SRDP, attach a *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes. A health plan change is not allowed when adding an SRDP due to a special open enrollment event if they are not a tax dependent.

If your spouse or SRDP is enrolled in Medicare, this information needs to match their Medicare records to avoid a delay in coverage starting.

Relationship to subscriber

☐ **Spouse:** Date of marriage

☐ **SRDP (Washington State):** Partnership start date

☐ **SRDP (non-Washington State):** Partnership start date

Social Security number

Date of birth

Sex assigned at birth[1]

☐ Male ☐ Female

Last name

Gender identity[2]

☐ Male ☐ Female ☐ X

First name

Middle initial

Suffix

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

1 This field is required for health care services.

2 Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit **hca.wa.gov/gender-x**.

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Subscriber's last name

Social Security number

Continue coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Add coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Terminate coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

⚠ If removing a spouse due to divorce, attach a copy of the divorce decree. If removing an SRDP due to dissolution, attach a copy of the dissolution of state-registered domestic partnership.

Termination date:

If terminating coverage, include reason:

Does this person receive Social Security Disability? ☐ Yes ☐ No

If Yes, effective date:

If Yes, attach a copy of their Social Security Disability Award letter. Write your full name and the last four digits of your Social Security number on the copy. You and your enrolled dependents may be eligible for additional months of coverage.

Is this person enrolled in Medicare Part A or B?

Part A (hospital)

☐ Yes ☐ No If Yes, enter effective dates shown on their Medicare card:

Part B (medical)

☐ Yes ☐ No If Yes, enter effective dates shown on their Medicare card:

Medicare number:

If Yes, proof is required. Attach a copy of their Medicare benefit verification letter or a copy of their Medicare card to this form. Write the subscriber's full name and last four digits of their Social Security number on the copy. **Your spouse or SRDP will not be enrolled until their proof of Medicare is received.**

⚠ Premium surcharges do not apply to subscribers who are enrolled in Medicare Part A and Part B.

Tobacco use premium surcharge

Response required if you are enrolling your spouse or SRDP in medical coverage. If you check Yes or do not check any boxes below, you will be charged the $25-per-account tobacco use premium surcharge in addition to your monthly premium.

Does the tobacco use premium surcharge apply to you? Check one:

☐ **No,** I am enrolled in Medicare Part A and Part B. The surcharge does not apply.

☐ **Yes,** I am subject to the $25 premium surcharge. This person has used tobacco products in the past two months.

☐ **No,** I am not subject to the $25 premium surcharge. This person has not used tobacco products in the past two months or has enrolled in or accessed one of the tobacco cessation resources.

Subscriber's last name

Social Security number

Spouse or state-registered domestic partner (SRDP) coverage premium surcharge

Response required if you are enrolling your spouse or SRDP in medical coverage. The PEBB Program requires a $50 premium surcharge in addition to your monthly medical premium if you enroll your spouse or SRDP in PEBB medical and they have chosen not to enroll in another employer-based group medical that is comparable to Uniform Medical Plan (UMP) Classic.

Answer these questions for your spouse or SRDP in 2025:	**Yes**	**No**
1. Are you covering your spouse or SRDP in a PEBB medical plan under your account?		
2. Will they be eligible for medical coverage through their employer? (If they will not be employed, answer No.)		
3. Will their employer offer at least one medical plan that serves their county of residence?		
4. Have they chosen not to enroll in their employer's medical (including SEBB) coverage?		
5. Will the coverage offered by their employer not be through the PEBB Program or a TRICARE plan? (Answer Yes if their employer does not offer PEBB coverage or a TRICARE plan. Answer No if their employer offers PEBB coverage or a TRICARE plan.)		
6. Will their share of the medical premium through their employer be less than $126.36 per month?		

If you answered No to **any** of these questions, check No below. You will not be charged the surcharge.
If you answered Yes to **all** of these questions:

1. Ask your spouse or SRDP for the Summary of Benefits and Coverage (SBC) for all medical plans that:
   a. Serve their county of residence.
   b. Have a monthly premium of less than $126.36 per month for the employee.
2. Use the SBC information to answer the questions in the *PEBB Spousal Plan Calculator* online tool. You will get a Yes or No response from the calculator. Enter this response below.

⚠ If you check Yes below or leave this section blank, you will be charged the $50 premium surcharge.

Does the spouse or SRDP coverage premium surcharge apply to you? Check one:

- **No,** I am enrolled in Medicare Part A and Part B. The surcharge does not apply.
- **Yes,** I am subject to the $50 premium surcharge. I completed the *PEBB Spousal Plan Calculator*.
- **No**, I am not subject to the $50 premium surcharge. If needed, I completed the *PEBB Spousal Plan Calculator*.
- The PEBB Program to help determine if the premium surcharge applies. I am submitting a printed *PEBB Spousal Plan Calculator*. The PEBB Program will use it to help determine whether my spouse's or SRDP's employer-based group medical is comparable to UMP Classic and whether I am subject to this premium surcharge.

The *PEBB Spousal Plan Calculator* is available at **hca.wa.gov/pebb-continuation** under *Surcharges*.

Subscriber's last name

Social Security number

3 Dependents

List eligible dependents you wish to add or remove from coverage. Enrolled children must be eligible under PEBB Program rules. This includes children through the month of their 26th birthday (regardless of marital status, student status, or eligibility for coverage under another plan), and children age 26 or older with a disability. You must also provide proof of their eligibility within the PEBB Program's enrollment timelines, or they will not be enrolled. Timelines and a list of documents we will accept to prove eligibility are available on HCA's website at **hca.wa.gov/pebb-continuation**.

Dependents cannot be enrolled in two PEBB medical, dental, or vision accounts at the same time.

If enrolling a state-registered domestic partner's child, an extended dependent, or a nonqualified tax dependent, attach a *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes. A health plan change is not allowed when adding an SRDP's child due to a special open enrollment event if they are not a tax dependent.

If enrolling an extended dependent, attach a *PEBB Extended Dependent Certification.*

If enrolling a child with a disability age 26 or older, attach a *PEBB Certification of a Child with a Disability*.

⚠ If adding more dependents, copy the dependents section and attach to this form.

Relationship to subscriber

- Child
- Stepchild (not legally adopted)
- Extended dependent (attach copy of court order)
- Child with a disability age 26 or older

Social Security number

Date of birth

Sex assigned at birth[1]

Male Female

Last name

Gender identity[2]

Male Female X

First name

Middle initial

Suffix

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

1 This field is required for health care services.

2 Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit **hca.wa.gov/gender-x**.

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Social Security number

Continue coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Add coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision

Terminate coverage (Select all that apply.)

☐ Medical ☐ Dental ☐ Vision Termination date:

If terminating coverage, include reason:

Does this person receive Social Security Disability? ☐ Yes ☐ No

If Yes, effective date:

If Yes, attach a copy of their Social Security Disability Award letter. Write your last name and the last four digits of your Social Security number on the copy. You and your enrolled dependents may be eligible for additional months of coverage.

Is this person enrolled in Medicare Part A or Part B?

Part A (hospital)

☐ Yes ☐ No If Yes, enter effective dates shown on their Medicare card:

Part B (medical)

☐ Yes ☐ No If Yes, enter effective dates shown on their Medicare card:

Medicare number:

If Yes, proof is required. Attach a copy of their Medicare benefit verification letter or a copy of their Medicare card to this form. Write the subscriber's full name and the last four digits of their Social Security number on the copy. **Your dependent will not be enrolled until their proof of Medicare is received.**

Tobacco use premium surcharge

Response required for dependents age 13 or older enrolling in medical coverage. If you check Yes or do not check any boxes below, you will be charged the $25-per-account tobacco use premium surcharge in addition to your monthly medical premium.

Does the tobacco use premium surcharge apply to you? Check one:

☐ **No**, I am enrolled in Medicare Part A and Part B. The surcharge does not apply.

☐ **Yes**, I am subject to the $25 premium surcharge. This dependent has used tobacco products in the past two months.

☐ **No**, I am not subject to the $25 premium surcharge. This dependent has not used tobacco products in the past two months or has enrolled in or accessed one of the tobacco cessation resources.

Subscriber's last name

Social Security number

4 Changes to an existing account

Are you making changes to an existing account?

☐ Yes If Yes, check all changes that apply in the sections below.

Date of event/change:

☐ No If No, go to Section 5.

Changes you can make anytime

☐ Name change

☐ Address change

☐ Terminate medical coverage for you or your enrolled dependents

☐ Terminate dental coverage for you or your enrolled dependents

☐ Terminate vision coverage for you or your enrolled dependents

☐ Remove dependents from coverage. If removal is due to loss of eligibility (divorce, annulment, dissolution, or dependent ceasing to be eligible as a child), the PEBB Program must receive this form **no later than 60 days** after the last day of the month the dependent loses eligibility. Coverage will be terminated the last day of the month of loss of eligibility.

If applicable, provide your former dependent's new address:

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

Changes you can make during annual open enrollment

All changes become effective January 1 of the following year. Check the box next to the changes requested.

☐ Add dependents ☐ Remove dependents ☐ Add or change medical plan

☐ Add or change dental plan ☐ Add or change vision plan

Changes you can make if an event creates a special open enrollment (SOE)

The PEBB Program only allows changes outside of annual open enrollment when an event creates an SOE. The change must be allowed under the Internal Revenue Code and Treasury regulations and correspond to and be consistent with an SOE event for the subscriber, the subscriber's dependents, or both. To disenroll from a Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP), the change in enrollment must be allowable under 42 C.F.R. Secs. 422.62(b) and 423.38(c). The PEBB Program must receive this form and proof of the event **no later than 60 days** after the event occurs.

To enroll a newborn or child whom you, the subscriber, have adopted or have assumed legal responsibility for support ahead of adoption, you should notify the PEBB Program by submitting the required forms as soon as possible. Doing so will ensure timely payment of claims. If adding the child increases the premium, the required forms must be received **no later than 60 days** after the date of the birth or adoption, or the date the legal responsibility is assumed ahead of adoption.

In most cases, the enrollment or change will be effective the first day of the month after the date of the event or the date we receive the form, whichever is later. Exceptions apply for new enrollment in a PEBB Medicare Supplement plan, a Medicare Advantage with Part D plan, or UMP Classic Medicare with Part D (PDP).

Note: A health plan change is not allowed when adding an SRDP or their child if they are not a tax dependent.

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Subscriber's last name

Social Security number

Check the box next to the applicable special open enrollment events below.

The following events allow a subscriber to add dependents or change medical, dental, or vision plans:

- ☐ Subscriber or dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- ☐ Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan.
- ☐ Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan.
- ☐ A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber.
- ☐ Subscriber or dependent enrolls in or loses eligibility for coverage under Medicaid or a state Children's Health Insurance Program (CHIP).
- ☐ Subscriber or dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- ☐ Subscriber or dependent loses eligibility for Medicare or enrolls in or terminates enrollment in a Medicare Advantage plan or Medicare Part D plan.
- ☐ Child becomes eligible as an extended dependent through legal custody or legal guardianship. Also complete a *PEBB Extended Dependent Certification* and *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes, available at **hca.wa.gov/pebb-continuation**.
- ☐ Marriage, registering a state-registered domestic partnership, birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption. You must also submit a *PEBB Declaration of Tax Status* if enrolling a state-registered domestic partner or their child to indicate whether they qualify as a dependent for tax purposes.

The following events allow a subscriber to add dependents:

- ☐ Subscriber or dependent has a change in enrollment under another employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- ☐ A dependent moves from another country to live within the United States or moves from within the United States to live in another country and the move resulted in the dependent losing their health insurance.

The following events allow a subscriber to change medical, dental, or vision plans:

- ☐ Subscriber or dependent has a change in residence that affects health plan availability.
- ☐ Subscriber's or dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account.
- ☐ Subscriber or dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent (requires approval by the PEBB Program).

5 Medical plan selection

Contact the plans with questions about benefits and providers. Their contact information is at the end of this form.

If you or an enrolled dependent are in a Medicare Advantage with Part D (MAPD) plan or UMP Classic Medicare with Part D (PDP), and are moving to another type of medical plan, also submit a *PEBB Medicare Plan Disenrollment form* (Form D) with this form. **Note:** If you choose a Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP), complete Section 9 of this form.

Choose one medical plan.

Kaiser Foundation Health Plan of the Northwest[1,2] (Kaiser Permanente NW)

- ☐ Kaiser Permanente NW Classic
- ☐ Kaiser Permanente NW Consumer-Directed Health Plan[5]
- ☐ Kaiser Permanente NW Senior Advantage with Part D[3]

Kaiser Foundation Health Plan of Washington[1] (Kaiser Permanente WA)

- ☐ Kaiser Permanente WA Classic[6]
- ☐ Kaiser Permanente WA Consumer-Directed Health Plan[5]
- ☐ Kaiser Permanente WA Medicare Advantage with Part D[3,4]
- ☐ Kaiser Permanente WA SoundChoice[1,6]
- ☐ Kaiser Permanente WA Value[6]

Premera Blue Cross

- ☐ Medicare Supplement Plan G[7]

Uniform Medical Plan (UMP), administered by Regence BlueShield and ArrayRx

- ☐ UMP Classic
- ☐ UMP Classic Medicare with Part D (PDP)[8]
- ☐ UMP Select[5]
- ☐ UMP Consumer-Directed Health Plan[5]
- ☐ UMP Plus–Puget Sound High Value Network[1,5]
- ☐ UMP Plus–UW Medicine Accountable Care Network[1,5]

UnitedHealthcare Medicare Advantage Prescription Drug

- ☐ UnitedHealthcare PEBB Balance (MAPD)[8]
- ☐ UnitedHealthcare PEBB Complete (MAPD)[8]

1. These plans have specific service areas. If you move out of the service area, you must change your plan. You must notify the PEBB Program no later than 60 days after you move or you will be enrolled in one.
2. Kaiser Foundation Health Plan of the Northwest (KFHPNW) offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon. KFHPNW Medicare plans have a larger service area.
3. These Medicare plans are available only in certain counties. See "Medical plans available by county" at **hca.wa.gov/pebb-continuation**.
4. If someone on your account is not enrolled in Medicare, also select Kaiser Permanente WA Classic, SoundChoice, or Value for them.
5. These plans are available only if you and your enrolled dependents are not enrolled in Medicare.
6. Only non-Medicare members can enroll in this plan. Members enrolled in Medicare will be enrolled in Kaiser Permanente WA Medicare Advantage with Part D.
7. Also submit Form B to enroll in this plan. It is only available to Medicare members. Any non-Medicare members on your account will be enrolled in UMP Classic.
8. These plans are only available to Medicare members. Any non-Medicare members on your account will be enrolled in UMP Classic.

6 Dental plan selection

Choose one dental plan. Before you enroll, make sure the provider you want to use accepts the specific plan and group you choose.

Preferred Provider Organization (PPO)

- **Uniform Dental Plan** (Group #03000), administered by Delta Dental of Washington. You can choose any dental provider and change providers at any time. Your out-of-pocket costs will be lower if you use a preferred provider.

Managed-Care Plans (limited network)

- **DeltaCare** (Group #03100), administered by Delta Dental of Washington. You must select a primary care dentist in the DeltaCare network.
- **Willamette Dental of Washington** (Group WA82), administered by Willamette Dental of Washington, Inc. You must select and receive care from a primary care dental provider in the Willamette Dental Group network.

7 Vision plan selection

Choose one vision plan (available to non-Medicare members only). Before you enroll, make sure the provider you want to use accepts the specific plan you choose. All non-Medicare members (subscribers or dependents) who want vision benefits must enroll in a vision plan. For Medicare members, vision is included in your medical plan, excluding Premera Plan G.

- **Davis Vision by MetLife**, underwritten by Metropolitan Life Insurance Company ("MetLife")
- **EyeMed Vision Care**, underwritten by Fidelity Security Life Insurance Company
- **MetLife Vision**, underwritten by Metropolitan Life Insurance Company ("MetLife")

⚠ Plan contact information is at the end of this form.

8 Signature

I have received and read the *PEBB Continuation Coverage Election Notice*, including appendices. By submitting this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plans. My dependents and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, the PEBB Program may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of PEBB insurance benefits.

If I send payment, this does not mean that I will be automatically enrolled in PEBB health plan coverage. The PEBB Program will verify eligibility for my dependents and me. If we do not qualify, I will receive a refund.

I understand I am responsible for paying any applicable tobacco use premium surcharge and spouse or state-registered domestic partner coverage premium surcharge in addition to my monthly medical premium.

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that the PEBB Program will direct a portion of my monthly premium to an HSA on my behalf based on the information I have provided, and that there are limits to these contributions and my HSA contributions (if any) under federal tax law.

Subscriber's last name

Social Security number

If I am electing to enroll in a Medicare Advantage with Part D (MAPD) or UMP Classic Medicare with Part D (PDP) plan, I certify that I have read and understand the Statement of Understanding in Section 9. I know that I must refer to the plan's certificate of coverage for rules I must follow to receive coverage under a PEBB Medicare Advantage contract. I understand that enrollment in an MAPD or UMP Classic Medicare with Part D (PDP) plan may not be retroactive. If I elect to enroll in a Kaiser MA plan, and the required forms are received by the PEBB Program after the date PEBB insurance coverage is to begin, my enrolled dependents and I will be enrolled in another Kaiser plan during the gap month(s) prior to when Kaiser MA coverage begins. If I elect to enroll in a UnitedHealthcare MAPD or UMP Classic Medicare with Part D (PDP) plan, and the required forms are received by the PEBB Program after the date PEBB insurance coverage is to begin, my enrolled dependents and I will be enrolled in UMP Classic during the gap month(s) prior to when the UnitedHealthcare MAPD or UMP Classic Medicare with Part D (PDP) plan begins. **This form cannot be signed more than 90 days before the effective date of this coverage.** (See Statement of Understanding in Section 9 for coverage effective date.)

I understand that my enrollment and my dependents' enrollment are subject to me abiding by all applicable deadlines and PEBB Program rules and policies. Failure to comply with applicable deadlines and PEBB Program rules and policies may result in my benefits selection being rejected.

This form replaces all *PEBB Continuation Coverage (COBRA) Election/Change* forms previously submitted to the PEBB Program.

Sign, date, and keep a copy for your records.

Subscriber's signature

Date

Spouse or SRDP signature [only required if enrolling in a Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP)]

Date

Dependent signature [only required if enrolling in a Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP)]

Date

Form return

Submit form and documentation using one of the methods below.

Mail to:

Washington State Health Care Authority
PO Box 42684
Olympia, WA 98504-2684

Fax to:

360-725-0771

If payment is enclosed, make it payable to Health Care Authority and mail to:

Washington State Health Care Authority
PO Box 42691
Olympia, WA 98504-2691

Secure message:

Send us a secure message through HCA Support at **support.hca.wa.gov**, a secure website that allows you to log in to your own account to communicate with us. You will need to set up a SecureAccess Washington (SAW) account to use this option.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-200-1004 (TRS: 711) or visit **hca.wa.gov/about-hca/nondiscrimination-statement**.

HCA's Privacy Notice: We will keep your information private as allowed by law. To see our Privacy Notice, go to the HCA website at **hca.wa.gov/pebb-continuation**.

9 Medicare Advantage with Part D or UMP Classic Medicare with Part D (PDP) agreement

This section applies only to subscribers enrolling in a Medicare Advantage with Part D (MAPD) or UMP Classic Medicare with Part D (PDP) plan. We offer four MAPD plans: Kaiser Permanente of the Northwest Senior Advantage with Part D, Kaiser Permanente of Washington Medicare Advantage with Part D, UnitedHealthcare PEBB Balance, and UnitedHealthcare PEBB Complete. We also offer UMP Classic Medicare with Part D (PDP). **If you or your dependent are not enrolling in one of these plans, skip this section.**

Statement of Understanding

I understand that beginning on my effective date with the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) I have selected in Section 5 of this form, as long as this form is signed prior to the effective date, all medical or prescription drug services, with the exception of emergency or out-of-area urgently needed services, must be provided or arranged for by the plan. Services rendered without prior authorization from my plan when required will not be reimbursed by the plan or Medicare, except for emergency services anywhere in the world or urgently needed services outside the plan's service area (or services provided under unusual and extraordinary circumstances when I am in the service area but my contracting medical group is temporarily unavailable or inaccessible).

I understand that the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) will release my information to Medicare, and Medicare may release it for research and other purposes that follow all applicable federal statutes and regulations.

I understand that I can be a member of only one Medicare Advantage with Part D plan or Part D plan at any time. By enrolling in the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) I have selected, I will automatically be disenrolled by the Centers for Medicare & Medicaid Services (CMS) from any other Medicare health or prescription drug plan of which I may be a member.

By enrolling in the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP), I authorize CMS to provide information to the plan I selected confirming my entitlement for Medicare Hospital Insurance Benefits (Part A) and Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of the Social Security Act. I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, if applicable. I also authorize the plan's provider or any other holder of medical or other relevant information about me to release to CMS or CMS's agents any information needed to administer Title XVIII of the Social Security Act.

I HEREBY AUTHORIZE any person including — but not limited to — physicians, hospitals, insurance companies and other organizations to release any information acquired by such person in the course of examination or treatment of myself, which is relevant to the provision or coordination of benefits or to professional review activities.

I understand that it is my responsibility to inform the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) I have selected before either permanently moving out of the service area or leaving the service area for more than six months in a row, and that my absence means the plan must disenroll me and return me to Original Medicare coverage.

I understand that I may disenroll from this Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) by sending a written request to the PEBB Program with ***Form D***. Until confirmation of the effective date of disenrollment, I must continue to receive health care from the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) providers.

I understand that as a member of the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP), I have the right to appeal service and payment denials made by the plan.

I understand that my enrollment in the Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) I have selected is effective the day PEBB insurance begins, or the first of the month after the PEBB Program receives my completed enrollment request, or effective as of my enrollment in both Medicare Parts A and B, whichever event occurs later, and may not be the same as my date of retirement. If I submit this form during the PEBB Program's annual open enrollment, then my enrollment is effective January 1 of the following year.

I understand that upon confirmation from CMS, the plan will send me written notice of my effective date of enrollment. I understand that when my coverage begins, I must get all of my medical (and prescription drug, if applicable) benefits from the plan. **Note:** Until you have received written notification of your effective date, you should not drop any supplemental insurance you have in effect now.

This form represents your temporary Medicare Advantage with Part D plan or UMP Classic Medicare with Part D (PDP) identification card. Until you receive your plan identification card, please keep a copy of this form with you and present it each time you require services from a contracted provider. Whenever possible, the Medicare Advantage with Part D organization or UMP Classic Medicare with Part D (PDP) provides the member, prior to the effective date, evidence of health insurance coverage so they may begin using the plan services as of the effective date of enrollment.

Please contact the plans if you need information in another language or format.

Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, and UnitedHealthcare and Moda as the administrator of the Part D portion of UMP Classic Medicare with Part D (PDP) have contracts with the federal government. Enrollment depends on contract renewal.

2025 PEBB Continuation Coverage (COBRA) Election/Change

Subscriber's last name

Social Security number

Medicare Advantage plan enrollment supplemental demographic information

Providing this demographic information is **optional** and will not affect your enrollment.

Preferred language other than English

- Spanish
- Other (please indicate) :
- No selected preference

Preferred accessible format

- Braille
- Large print
- Audio CD
- No selected preference

Subscriber

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- Not of Hispanic, Latino/a, or Spanish origin
- Puerto Rican
- Another Hispanic, Latino/a, or Spanish origin
- Mexican, Mexican American, Chicano/a
- Cuban
- I choose not to answer

Which of the following best describes you? Select all that apply.

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Samoan
- Guamanian or Chamorro
- Other Pacific Islander
- A race/ethnicity not listed
- I choose not to answer

Spouse or SRDP

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- Not of Hispanic, Latino/a, or Spanish origin
- Puerto Rican
- Another Hispanic, Latino/a, or Spanish origin
- Mexican, Mexican American, Chicano/a
- Cuban
- I choose not to answer

Which of the following best describes you? Select all that apply.

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Samoan
- Guamanian or Chamorro
- Other Pacific Islander
- A race/ethnicity not listed
- I choose not to answer

Dependent

Are you of Hispanic, Latino/a, or Spanish origin? Select all that apply.

- Not of Hispanic, Latino/a, or Spanish origin
- Puerto Rican
- Another Hispanic, Latino/a, or Spanish origin
- Mexican, Mexican American, Chicano/a
- Cuban
- I choose not to answer

Which of the following best describes you? Select all that apply.

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Samoan
- Guamanian or Chamorro
- Other Pacific Islander
- A race/ethnicity not listed
- I choose not to answe

PEBB Program contractors

⚠ Do not send forms to the addresses below. This information is only for your reference.

Medical

Kaiser Foundation Health Plan of the Northwest

500 NE Multnomah St., Suite 100
Portland, OR 97232-5398
1-800-813-2000 (TRS: 711)
Medicare members: 1-877-221-8221 (TRS: 711)

Kaiser Foundation Health Plan of Washington

2715 Naches Ave. SW
Renton, WA 98057
1-866-648-1928, TTY: 1-800-833-6388
MAPD: 1-888-901-4600

Premera Blue Cross

PO Box 327, MS 295
Seattle, WA 98111
425-918-4000

Uniform Medical Plan, administered by Regence BlueShield
(for medical benefits)

PO Box 1106
Lewiston, ID 83501-1106
1-888-849-3681 (TRS: 711)

Uniform Medical Plan, administered by ArrayRx
(for prescription drug questions)

Non-Medicare members:
PO Box 40168
Portland, OR 97240-0168
1-888-361-1611 (TRS: 711)

Medicare members:
PO Box 40327
Portland, OR 97240-0327
1-833-599-8539 (TRS: 711)

UnitedHealthcare

185 Asylum Ave.
Hartford, CT 06103
1-855-873-3268

Dental

DeltaCare, administered by Delta Dental of Washington

400 Fairview Ave. N, Suite 800
Seattle, WA 98109-5371
1-800-650-1583
TTY: 1-800-833-6384

Uniform Dental Plan, administered by Delta Dental of Washington

400 Fairview Ave. N, Suite 800
Seattle, WA 98109-5371
1-800-537-3406
TTY: 1-800-833-6384

Willamette Dental of Washington, Inc.

6950 NE Campus Way
Hillsboro, OR 97124-5611
1-855-433-6825 (TRS: 711)

Vision

Davis Vision by MetLife, underwritten by Metropolitan Life Insurance Company

Vision Care Processing Unit
200 Park Ave.
New York, NY 10166
1-888-496-4275
TTY: 1-800-523-2847

EyeMed Vision Care, underwritten by Fidelity Security Life Insurance Company

1209 Orange St.
Wilmington, DE 19801
1-800-699-0993
TTY: 1-844-230-6498

Metropolitan Life Insurance Company (Vision Plan)

200 Park Ave.
New York, NY 10166
1-866-548-7139
TTY: 1-800-428-4833

Vision Service Plan

PO Box 997100
Sacramento, CA 95899-7100
1-844-299-3041 (TTY: 1-800-428-4833)