Clear form

HCA | Health Care Authority
School Employees Benefits Board

# 2025 School Employee Enrollment Form

**Use this form only if you are unable to use Benefits 24/7 at benefits247.hca.wa.gov.**

The information written on this form replaces all enrollment forms previously submitted. Therefore, you must complete the entire form, including the dependent section for any children you wish to continue to cover. Inaccurate, incomplete, or illegible information may delay coverage.

To make changes, submit the *School Employee Change Form* to your payroll or benefits office.

All members who are eligible for both the SEBB Program and Public Employees Benefits Board (PEBB) Program must choose health plan enrollment through one program. Choosing some plans in both programs is not allowed.

Type or print clearly in blue or black ink and use all capital lettering in the spaces provided. Example: J O H N

⚠ Remember to read and sign Section 7.

## 1 Subscriber

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

Mailing address (if different from above)

Mailing address line 2

City

State

ZIP/Postal code

County

Are you or your dependents enrolled in SEBB or PEBB insurance coverage under another account? ☐ Yes ☐ No

⚠ If yes, please contact your payroll or benefits office for help.

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's website at **hca.wa.gov/gender-x**.



HCA 20-0055 (8/24)

## 2025 SEBB Employee Enrollment Form

Subscriber's last name

Social Security number

## Choose one box for each type of coverage.

| Medical coverage | Dental coverage | Vision coverage |
|---|---|---|
| ☐ Cover | ☐ Cover | ☐ Cover |
| ☐ Waive | ☐ Waive (Dental may only be waived if you enroll in PEBB dental and vision.) | ☐ Waive (Vision may only be waived if you enroll in PEBB dental and vision.) |

⚠ **If you waive medical coverage for yourself, you cannot enroll your dependents in medical coverage. You can waive SEBB medical coverage if you are enrolled in other employer-based group medical, a TRICARE plan, or Medicare.**

## Tobacco use premium surcharge

Response required if you are enrolling in medical coverage. The SEBB Program requires a $25-per-account premium surcharge in addition to your monthly medical premium if you or an enrolled dependent (age 13 or older) uses a tobacco product. The surcharge doesn't apply to dependents under age 13. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. Refer to the *School Employee Enrollment Guide* or visit HCA's website at **hca.wa.gov/sebb-employee** to learn more.

If you check Yes or leave this section blank, you will be charged the $25 premium surcharge.

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

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

☐ **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 the tobacco cessation resources noted in the *School Employee Enrollment Guide*.

## 2025 SEBB Employee Enrollment Form

Subscriber's last name

Social Security number

## 2 Spouse or State-registered domestic partner (SRDP)

List a spouse or SRDP you wish to enroll. State-registered domestic partner is defined in WAC 182-31-020. State-registered domestic partners include partners of a legal union 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 provide proof of your spouse or SRDP's eligibility within the SEBB Program's timelines, or they will not be enrolled. Timelines and a list of acceptable documents to verify eligibility is available on HCA's website at **hca.wa.gov/sebb-employee**.

If your spouse or SRDP is eligible to enroll in both the PEBB and SEBB Programs, they are limited to a single enrollment in medical, dental, and vision plans from either the SEBB Program or PEBB Program as described in WAC 182-31-070. They may not be enrolled in both programs.

### Relationship to subscriber. Choose one.

- Spouse: Date of marriage (mm/dd/yyyy)
- SRDP (Washington State): Partnership start date (mm/dd/yyyy)
- SRDP (non-Washington State): Partnership start date (mm/dd/yyyy)

**If enrolling an SRDP, also submit a *SEBB Declaration of Tax Status* form to indicate whether they qualify as a dependent for tax purposes.**

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 (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

### Choose one box for each type of coverage.

| Medical coverage | Dental coverage | Vision coverage |
|---|---|---|
| Add to coverage | Add to coverage | Add to coverage |
| Decline coverage | Decline coverage | Decline coverage |

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's website at **hca.wa.gov/gender-x**.

## 2025 SEBB Employee Enrollment Form

Subscriber's last name

Social Security number

## Tobacco use premium surcharge

Response required if you are enrolling your spouse or state-registered domestic partner (SRDP) in medical coverage. If you check **Yes** or do not check any boxes below, you will be charged the $25-per-account premium surcharge in addition to your monthly medical premium. See page 2 for how to respond.

**Does the tobacco use premium surcharge apply to your spouse or state-registered domestic partner?** Check one:

☐ **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 noted in the *School Employee Enrollment Guide*.

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

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

**Answer these questions for your spouse or SRDP in 2025:**

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

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 *SEBB Spousal Plan Calculator* online tool. You will get a Yes or No response from the calculator. Enter this response on the next page.

## 2025 SEBB Employee Enrollment Form

Subscriber's last name

Social Security number

**Does the spouse or state-registered domestic partner coverage surcharge apply to you?**
Check one:

⚠ **If you check Yes or do not check any boxes, you will be charged the $50 premium surcharge.**

☐ **Yes**, I am subject to the $50 premium surcharge. I completed the *SEBB Spousal Plan Calculator*.

☐ **No**, I am not subject to the $50 premium surcharge. If needed, I completed the *SEBB Spousal Plan Calculator*.

☐ Employer to help determine if premium surcharge applies. I am submitting a printed *SEBB Spousal Plan Calculator*. My employer will use these to help determine whether my spouse's or state-registered domestic partner's employer-based group medical is comparable to PEBB's UMP Classic plan and whether I am subject to this premium surcharge.

## 2025 SEBB Employee Enrollment Form

Subscriber's last name

Social Security number

## 3 Dependents

List dependents you wish to enroll. They must be eligible under SEBB 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. It also includes children age 26 or older with a disability. Use additional forms for more dependents.

You must provide proof of their eligibility within the SEBB Program's enrollment timelines or they will not be enrolled. Timelines and a list of acceptable documents to verify eligibility are available on HCA's website at **hca.wa.gov/sebb-employee**.

If adding a state-registered domestic partner's child, extended dependent, or other nonqualified tax dependent, also attach a *SEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes.

If enrolling an extended dependent, attach a *SEBB Extended Dependent Certification,* a valid court order showing legal custody or guardianship, and a *SEBB Declaration of Tax Status*.

If enrolling a child with a disability (age 26 or older), attach a *SEBB Certification of a Child with a Disability* and submit it as instructed on the form.

**Relationship to subscriber**

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

**If they are eligible to enroll in both the SEBB and PEBB Programs, they are limited to a single enrollment in medical, dental, or vision from either the PEBB Program or SEBB Program as described in WAC 182-31-070. They may not be enrolled in both programs.**

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 (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

### Choose one box for each type of coverage.

| Medical coverage | Dental coverage | Vision coverage |
|---|---|---|
| Add to coverage | Add to coverage | Add to coverage |
| Decline coverage | Decline coverage | Decline coverage |

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's website at **hca.wa.gov/gender-x**.

Subscriber's last name

Social Security number

## Tobacco use premium surcharge

Response required if you are enrolling dependents age 13 and older in medical coverage.

If you check **Yes** or do not check any boxes below, you will be charged the $25-per-account premium surcharge in addition to your monthly medical premium. See page 2 of this form for instructions on how to respond.

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

- **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 dependent has not used tobacco products in the past two months or has enrolled in or accessed one of the tobacco cessation resources listed in the *School Employee Enrollment Guide*.

Subscriber's last name

Social Security number

## 4 Medical plan selection

Choose one medical plan.

**Kaiser Foundation Health Plan of the Northwest (Kaiser Permanente NW)**

- ☐ Kaiser Permanente NW 1
- ☐ Kaiser Permanente NW 2
- ☐ Kaiser Permanente NW 3

**Kaiser Foundation Health Plan of Washington (Kaiser Permanente WA)**

- ☐ Kaiser Permanente WA Core 1
- ☐ Kaiser Permanente WA Core 2
- ☐ Kaiser Permanente WA Core 3
- ☐ Kaiser Permanente WA SoundChoice

**Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente WA Options)**

- ☐ Kaiser Permanente WA Options Summit PPO 1
- ☐ Kaiser Permanente WA Options Summit PPO 2
- ☐ Kaiser Permanente WA Options Summit PPO 3

**Premera Blue Cross**

- ☐ Premera High PPO
- ☐ Premera HMO
- ☐ Premera Standard PPO

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

- ☐ UMP Achieve 1
- ☐ UMP Achieve 2
- ☐ UMP High Deductible
- ☐ UMP Plus–Puget Sound High Value Network
- ☐ UMP Plus–UW Medicine Accountable Care Network

⚠ Information about medical plan options can be found on HCA's website **hca.wa.gov/sebb-employee**. Call the plans with questions about benefits and provider information. Before you enroll, call the plan to make sure the provider you want to use accepts the specific plan you choose. (Contact information is on page 12 of this form.)

If you are eligible for SEBB benefits, but do not waive or enroll in SEBB medical coverage, you will be automatically enrolled as a single subscriber in Uniform Medical Plan (UMP) Achieve 1. Your dependents will not be enrolled. You will be charged a monthly premium for medical coverage as well as a $25 monthly tobacco use premium surcharge.

These plans have specific service areas. You must live or work in the medical plan's service area to join the plan. All school employees are offered a choice of plans based on their county of residence or the county where their employment location is based. If you work in a district that crosses county lines, identify all counties your school district is in to see all plan options available. **Exception**: To enroll in a UMP Plus plan, you must live in the service area.

If you move out of the medical plan's service area or change jobs to a different employment location, and your current medical plan is no longer available, you must select a new plan. If you do not, the SEBB Program will enroll you in a plan. You must report your new address and any request to change your health plan to your payroll or benefits office **no later than 60 days** after your move.

Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties in Oregon.

Subscriber's last name

Social Security number

## 5 Dental plan selection

Choose one dental plan in this section. Before you enroll, call the plan to make sure the provider you want to use accepts the specific plan and group you choose. If you do not select a dental plan, you will be automatically enrolled in Uniform Dental Plan (Group #09600).

**Preferred Provider Organization (PPO)**

☐ **Uniform Dental Plan** (Group #09600), administered by Delta Dental of Washington
You can choose any dental provider and change providers at any time.

**Managed-care plans (limited network)**

☐ **DeltaCare** (Group #09601), administered by Delta Dental of Washington.
You must select a primary care dentist in the DeltaCare network.

☐ **Willamette Dental of Washington, Inc.** (Group WA 733), administered by Willamette Dental Group. You will select and receive care from a primary care dental provider in the Willamette Dental Group network.

## 6 Vision plan selection

Choose one vision plan in this section. Before you enroll, call the plan to make sure the provider you want to use accepts the specific plan you choose. If you do not choose a vision plan, you will be automatically enrolled in MetLife Vision.

☐ **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")

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

Subscriber's last name

Social Security number

## 7 Signature

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 the SEBB Program rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plans or premiums paid on my behalf. My dependents and I may also lose SEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, the SEBB Program or my employer may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility. 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 SEBB insurance benefits.

If adding a state-registered domestic partner (SRDP) to my account, I declare that my domestic partner and I have registered through the Washington Secretary of State's Office or another state.

Enrollment is not complete until the SEBB Program verifies the eligibility of my dependents. I understand if I am applying to add a dependent to my SEBB insurance coverage, I must provide copies of documents that verify the dependent's eligibility within the SEBB Program's enrollment timelines, or the dependent will not be enrolled.

If I am eligible for the employer contribution toward SEBB benefits but do not waive or enroll in SEBB medical coverage, I will be enrolled automatically as a single subscriber in Uniform Medical Plan (UMP) Achieve 1. My dependents will not be enrolled. I will be charged a monthly premium for medical coverage as well as a $25 monthly tobacco use premium surcharge.

Employees must enroll in SEBB dental, vision, basic life, basic accidental death and dismemberment, and employer-paid long-term disability (LTD) insurance. Enrollment in employee-paid LTD insurance is automatic. Employees can choose a lower cost coverage level or decline coverage.

Employees who choose to waive SEBB medical coverage must be enrolled in other employer-based group medical, a TRICARE plan, or Medicare. If I waive medical coverage, I understand I can enroll during the annual open enrollment period or **no later than 60 days** after a special open enrollment event as defined in the SEBB Program rules. If I waive medical coverage for myself, I cannot enroll my eligible dependents in medical coverage

I allow my employer to deduct money from my earnings to pay for insurance coverage and any applicable premium surcharges. I understand I am responsible for paying applicable tobacco use premium surcharge and spouse or SRDP coverage premium surcharge in addition to my monthly premium.

If I enroll in a high-deductible health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that my employer will contribute 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.

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

This form replaces all enrollment forms previously submitted, including any changes made in the online enrollment system.

### Sign, date, and return form and documentation to your payroll or benefits office.

Subscriber's signature

Date

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please contact your payroll or benefits office.

**HCA's Privacy Notice**: HCA will keep your information private as allowed by law. To see our Privacy Notice, go to **hca.wa.gov/sebb-employee**.

## 2025 SEBB Employee Enrollment Form

Subscriber's last name

Social Security number

## 8 Employer

**⚠ This section to be completed by a school district, charter school, or educational service district benefits administrator.**

HCA Code

Organization number

Organization name

Organization name (continued)

**Eligibility: Check one**

- ☐ Subscriber is SEBB-eligible
- ☐ Subscriber is locally eligible

Eligibility date

Effective date

**Represented?**

- ☐ Yes, if yes date they became represented
- ☐ No

## SEBB Program contractors

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

### Medical contractors

**Kaiser Foundation Health Plan of the Northwest**
500 NE Multnomah St.,
Suite 100
Portland, OR 97232
1-800-813-2000 (TRS: 711)

**Kaiser Foundation Health Plan of Washington**
2715 Naches Ave SW
Renton, WA 98057
1-888-901-4636
TTY: 1-800-833-6388 (TRS: 711)

**Kaiser Foundation Health Plan of Washington Options, Inc.**
2715 Naches Ave SW
Renton, WA 98057
1-888-901-4636
TTY: 1-800-833-6388 (TRS: 711)

**Premera Blue Cross**
High PPO and Standard PPO
7001 220th St. SW
Mountlake Terrace, WA 98043
1-800-807-7310
TTY: 1-800-842-5357 (TRS: 711)

**Premera Blue Cross HMO**
7001 220th St. SW
Mountlake Terrace, WA 98043
1-800-807-7310
TTY: 1-800-842-5357 (TRS: 711)

**Uniform Medical Plan,** administered by Regence BlueShield (for medical benefit questions)
PO Box 1106
Lewiston, ID 83501-1106
1-800-628-3481 (TRS: 711)

**Uniform Medical Plan**, administered by ArrayRx (for prescription drug questions)
PO Box 40168
Portland, OR 97240-0327
1-833-599-8539 (TRS: 711)

### 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 Inc. by MetLife**, underwritten by Metropolitan Life Insurance ("MetLife")
200 Park Avenue
New York, NY 10166
1-877-377-9353
TTY: 1-800-523-2847

**EyeMed Vision Care**, underwritten by Fidelity Security Life Insurance Company
1209 Orange Street
Wilmington, DE 19801
1-800-699-0993
TTY: 1-844-230-6498

**Metropolitan Life Insurance Company** (Vision Plan)
200 Park Avenue
New York, NY 10166
1-833-854-9624
TTY: 1-800-428-4833