



## 2022 PEBB Retiree Election Form (form A)

Complete this form to enroll in or defer (postpone) enrollment in PEBB retiree insurance coverage. If you wish to make a change to an existing retiree account, please use the *PEBB Retiree Change Form* (form E). All forms and documents mentioned, and a self-paced tutorial about how to complete this form, are available on HCA's website at [hca.wa.gov/pebb-retirees](https://hca.wa.gov/pebb-retirees).

Remember to read and sign Section 7. To enroll dependents, fill out Section 8. This form replaces all retiree enrollment/change forms submitted in the past.

Type or print in dark ink using all capital lettering in the spaces provided. Inaccurate, incomplete, or illegible information may delay coverage.

Example: J O H N

### Required

### General information

#### Retiree, employee, or school employee information only

If you are a surviving spouse, state-registered domestic partner (defined in WAC 182-12-109), or dependent, provide the deceased employee or retiree's information below. Provide your personal information in Section 1.

Retiree, employee, or school employee last name

Social Security number

Retirement plan

Retirement date (or separation date for plan 3 or higher-education retirement plans)

#### Check one:

**Enrolling:** I am a new retiree or a surviving dependent requesting to enroll in coverage.

**Deferring:** I am a new retiree or a surviving dependent deferring (postponing) my coverage. Select your reason for deferral in Section 1. See the *PEBB Retiree Enrollment Guide* for details about deferring.

**Enrolling after deferring:** Date other qualifying medical coverage ended  
With this form, you must provide proof of your continuous enrollment in other qualifying coverages since your date of deferral.

**Separating:** Eligible under Plan 3 or a higher-education retirement plan,  
separating as of

#### For new nonrepresented employees of a Washington State educational service district who are retiring:

Educational Service District (ESD)

When does your current health plan coverage through your ESD, COBRA, or continuation coverage end?

**Note:** If you are applying to enroll in retiree insurance coverage after your COBRA or continuation coverage ends, you must submit proof of your continuous health coverage with this form.

## 2022 PEBB Retiree Election Form

Subscriber's last name

Social Security number

1

### Subscriber

Social Security number

Date of birth (mm/dd/yyyy)

Sex assigned at birth<sup>1</sup>

Last name

Male Female  
Gender identity<sup>2</sup>

First name

Male Female X  
Middle initial Suffix

Phone number

Alternate phone number

Street address

Address line 2

City

State

ZIP/Postal code

County

Mailing address (if different)

Mailing address line 2

City

State

ZIP/Postal code

County

### Are you enrolled in Medicare Part A or Part B?

Part A (hospital) Yes No If Yes, enter effective date from Medicare card:

Part B (medical) Yes No If Yes, enter effective date from Medicare card:

If Yes, proof is required. Attach a copy of your entire entitlement letter or a copy of your Medicare card to this form if we don't already have a copy. If you are eligible for Medicare, you must enroll and stay enrolled in both Part A and Part B to keep PEBB retiree health plan coverage.

I am in the process of enrolling in Medicare Part A and Part B. I will submit proof after I receive my entitlement letter or Medicare cards.

### Are you enrolled in Medicare Part D (prescription drug coverage)?

Yes No If Yes, effective date:

If Yes, you may enroll only in Premera Blue Cross Medicare Supplement Plan G. If you want to enroll in any other PEBB medical plan, you must disenroll from your Part D plan.

<sup>1</sup> This field is required for health care services.

<sup>2</sup> 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](https://hca.wa.gov/gender-x).

## 2022 PEBB Retiree Election Form

Subscriber's last name

Social Security number

### Are you enrolled in Medicaid with Medicare Part D?

Yes      No      If Yes, effective date:

### I wish to:

**Enroll:** (Check all that apply.)

Medical only

Medical and dental

Retiree term life insurance

**Defer:** Defer (postpone) my coverage. Except as stated below, this defers coverage for all eligible dependents.

Deferral date:

**Enroll after deferring coverage:** You will need to provide proof of continuous enrollment in one or more qualifying coverages (with start and end dates). A gap in coverage of 31 days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of a qualifying coverage, and between each qualifying coverage.

Date other qualifying coverage ended:

### If deferring or enrolling after deferring, check the box(es) below that apply to you.

Enrolled as a dependent in a health plan sponsored by the PEBB Program, a Washington State educational service district, or a School Employees Benefits Board (SEBB) Program. This includes coverage under COBRA or continuation coverage.

Enrolled in employer-based group medical as an employee or employee's dependent, including medical insurance continued under COBRA or continuation coverage. This does not include an employer's retiree coverage.

Enrolled in medical coverage as a retiree or dependent of a retiree in a TRICARE plan or the Federal Employees Health Benefits Program. You have a one-time opportunity to enroll in a PEBB retiree health plan.

Enrolled in a Medicaid program that provides creditable coverage and in Medicare Part A and Part B. You may continue to cover eligible dependents who are not eligible for creditable coverage under Medicaid.

Enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). You have a one-time opportunity to enroll in a PEBB retiree health plan.

**Non-Medicare subscribers only:** Enrolled in qualified health plan coverage through a health benefit exchange established under the Affordable Care Act. This does not include Medicaid (called Apple Health in Washington State). You have a one-time opportunity to enroll or reenroll in a PEBB retiree health plan.

 The premium surcharges only apply to subscribers who are **not** 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 premium surcharge in addition to your monthly medical premium if you or an enrolled dependent (age 13 or older) 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. If a provider finds that ending tobacco use or participating in your medical plan's tobacco cessation program will negatively affect your or your dependent's health, see more information in the PEBB Program Administrative Policy 91-1 on HCA's website at [hca.wa.gov/pebb-rules](https://hca.wa.gov/pebb-rules).

If you check Yes or do not check any boxes below, you will be charged the \$25 premium surcharge. See the *2022 PEBB Premium Surcharge Attestation Help Sheet* available at [hca.wa.gov/pebb-retirees](https://hca.wa.gov/pebb-retirees) for instructions on how to respond.

### 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.

**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 in the *PEBB Premium Surcharge Attestation Help Sheet*.

## 2022 PEBB Retiree Election Form

Subscriber's last name

Social Security number


2

### Spouse or state-registered domestic partner (SRDP)


List an eligible spouse or SRDP you wish to cover. SRDP is defined in Washington Administrative Code 182-12-109. Dependents cannot be enrolled in two PEBB medical or dental accounts at the same time. To enroll children, please complete Section 8 at the end of this form.

#### Relationship to subscriber

Spouse: date of marriage

 Non-Medicare subscribers: If enrolling a spouse, you must provide proof of their eligibility within the PEBB Program's enrollment timelines, or they will not be enrolled. A list of documents we will accept to prove their eligibility is available on HCA's website at [hca.wa.gov/pebb-retirees](https://hca.wa.gov/pebb-retirees).

SRDP: date registered

 All subscribers: If enrolling an SRDP, attach a *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(B). 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-retirees](https://hca.wa.gov/pebb-retirees).

Social Security number

Date of birth

Sex assigned at birth<sup>1</sup>

Male

Female

Last name

Gender identity<sup>2</sup>

Male

Female

X

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address (if different from subscriber's)

Address line 2

City

State

ZIP/Postal code

County

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

Part A (hospital)      Yes      No    If Yes, enter effective date from Medicare card:

Part B (medical)      Yes      No    If Yes, enter effective date from Medicare card:

If Yes, proof is required. Attach a copy of their entire entitlement letter or a copy of their Medicare card to this form if we don't already have a copy. Write your full name and the last four digits of your Social Security number on the copy. If your dependent is eligible for Medicare, they must enroll and stay enrolled in Part A and Part B to keep PEBB retiree health plan coverage.

They are in the process of enrolling in Medicare Part A and Part B. They will submit proof after they receive their entitlement letter or Medicare cards.

<sup>1</sup> This field is required for health care services.

<sup>2</sup> 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](https://hca.wa.gov/gender-x).

## 2022 PEBB Retiree Election Form

Subscriber's last name

Social Security number

### Is this person enrolled in Medicare Part D (prescription drug coverage)?

Yes      No      If Yes, effective date:

If Yes, you may enroll only in Premiera Blue Cross Medicare Supplement Plan G. If you want to enroll in any other PEBB medical plan, you must disenroll from the Part D plan.

### Is this person enrolled in Medicaid with Medicare Part D?

Yes      No      If Yes, effective date:

 The premium surcharges only apply to subscribers who are **not** 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 premium surcharge. See the *2022 PEBB Premium Surcharge Attestation Help Sheet* available at [hca.wa.gov/pebb-retirees](https://hca.wa.gov/pebb-retirees) for instructions on how to respond.

#### 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. 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 they have enrolled in or accessed one of the tobacco cessation resources noted in the *PEBB Premium Surcharge Attestation Help Sheet*.

### 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 are enrolling 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 Classic.

#### 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 premium surcharge does not apply.

**Yes**, I am subject to the \$50 premium surcharge. I used the *PEBB Premium Surcharge Attestation Help Sheet* and completed the *PEBB Spousal Plan Calculator* online.

**No**, I am not subject to the \$50 premium surcharge. I used the *PEBB Premium Surcharge Attestation Help Sheet* and, if needed, completed the *PEBB Spousal Plan Calculator* online. Which questions on the *PEBB Premium Surcharge Attestation Help Sheet* did you check No? Check all that apply. Question 1 is not applicable.

Question 2


Question 3

Question 4

Question 5

Question 6

The PEBB Program to help determine if the premium surcharge applies. I used the *PEBB Premium Surcharge Attestation Help Sheet* and am submitting a printed *PEBB Spousal Plan Calculator*.

 If you check **Yes** or do not check any boxes in this section, you will be charged the \$50 premium surcharge. See the *2022 PEBB Premium Surcharge Attestation Help Sheet* on HCA's website at [hca.wa.gov/pebb-retirees](https://hca.wa.gov/pebb-retirees) for instructions on how to respond.

## 2022 PEBB Retiree Election Form

Subscriber's last name

Social Security number

3

### Medical plan selection

Contact the plans with questions about benefits and providers. Contact information is on page 10 of this form.

#### Kaiser Foundation Health Plan of the Northwest<sup>1</sup>

Kaiser Permanente NW Classic<sup>2</sup>

Kaiser Permanente NW Consumer-Directed Health Plan<sup>2,5</sup>

Kaiser Permanente NW Senior Advantage<sup>3</sup>

#### Kaiser Foundation Health Plan of Washington<sup>1</sup>

Kaiser Permanente WA Classic<sup>7</sup>

Kaiser Permanente WA Consumer-Directed Health Plan<sup>5</sup>

Kaiser Permanente WA Medicare Plan<sup>3,4</sup>

Kaiser Permanente WA SoundChoice<sup>6,7</sup>

Kaiser Permanente WA Value<sup>7</sup>

#### Premiera Blue Cross

Medicare Supplement Plan G<sup>8</sup>

#### Uniform Medical Plan (UMP), administered by Regence BlueShield

UMP Classic

UMP Select<sup>5</sup>

UMP Consumer-Directed Health Plan<sup>5</sup>

UMP Plus–Puget Sound High Value Network<sup>1,5</sup>

UMP Plus–UW Medicine Accountable Care Network<sup>1,5</sup>

#### UnitedHealthcare Medicare Advantage Prescription Drug

UnitedHealthcare PEBB Balance<sup>9</sup>

UnitedHealthcare PEBB Complete<sup>9</sup>

<sup>1</sup> These plans have specific service areas. If you move out of the service area, you must change your plan. Otherwise, you will have limited access to network providers and covered services. You must notify the PEBB Program **no later than 60 days** after you move.

<sup>2</sup> 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.

<sup>3</sup> These Medicare plans are available only in certain counties. See “Medical plans available by county” at [hca.wa.gov/pebb-retirees](https://hca.wa.gov/pebb-retirees). Submit Form C with this form if you live in a county where a Medicare Advantage plan is available.

<sup>4</sup> If someone on your account is not enrolled in Medicare, also select Kaiser Permanente WA Classic, SoundChoice, or Value for them.

<sup>5</sup> These plans are available only if you and your enrolled dependents are not enrolled in Medicare.

<sup>6</sup> Not all contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before your visit.

<sup>7</sup> Only non-Medicare members can enroll in this plan. Members enrolled in Medicare will be enrolled in Kaiser Permanente WA's Medicare Plan.

<sup>8</sup> 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.

<sup>9</sup> Also submit Form C to enroll in these plans. They are only available to Medicare members. Any non-Medicare members on your account will be enrolled in UMP Classic.

## 2022 PEBB Retiree Election Form

Subscriber's last name

Social Security number

### 4

### Dental plan selection

You must enroll in medical coverage to enroll in dental. Before you enroll, call the dental plan to make sure your provider accepts the specific plan and plan group you choose. Their contact information is on page 10 of this form.

#### Preferred Provider Organization (PPO)

**Uniform Dental Plan** (Group #3000), 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 #3100), administered by Delta Dental of Washington. You must select a primary care dentist in the DeltaCare network.

**Willamette Dental Group of Washington** (Group WA82), administered by Willamette Dental of Washington, Inc. You will select and receive services from a provider in the Willamette Dental Group network.

### 5

### Retiree term life insurance

Retiree term life insurance is available only if you received PEBB life insurance as an employee or SEBB life insurance as a school employee. You are not eligible for the retiree term life insurance plan if you qualify for a waiver of premium benefit under the PEBB employee life insurance or SEBB employee life insurance plans. To apply for retiree term life insurance, submit the *MetLife Enrollment/Change Form for Retiree Plan* (including beneficiary designation) to the PEBB Program with this form.

I acknowledge that I have completed the *MetLife Enrollment/Change form for Retiree Plan* and will return it with this form.

## 2022 PEBB Retiree Election Form

Subscriber's last name

Social Security number

6

### Payment

You have three payment options: pension deduction, invoicing, and Electronic Debit Service. In most cases, you must make your first payment by check before we can enroll you.

#### How to make the first payment

If you select Electronic Debit Service (EDS) or invoicing below, you must make your first payment by check. Your first premium payment and applicable premium surcharges are due **no later than 45 days** after your 60-day election period ends. We will not enroll you in coverage until we receive your first payment. If you miss this deadline, you may lose your right to enroll in PEBB retiree insurance coverage. Make your check payable to Health Care Authority. Send it (and your EDS form, if you choose that option) to:

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

If you select pension deduction below, the PEBB Program will send you an invoice if the first payment is needed. Due to timing issues with the Department of Retirement Systems, a first payment may be required for premiums and applicable premium surcharges that were not deducted from your pension. If you receive an invoice, you must pay by check until your pension deduction is set up.

You cannot have a gap in coverage. Premiums are due back to the first of the month in which your PEBB retiree coverage was effective. Premiums and applicable premium surcharges are for a full month of coverage and cannot be prorated for a partial month. Payments are processed immediately as required by state law.

#### How would you like to pay?

**Electronic Debit Service (EDS):** I will pay my monthly medical and dental premiums (if elected) and applicable premium surcharges by EDS. I will submit the *PEBB Electronic Debit Service (EDS) Agreement* available in the *Retiree Enrollment Guide*. I understand I must pay by check until I am notified of my EDS effective date, and that I must make my first payment before I will be enrolled. I understand I will receive a separate bill from MetLife for my retiree term life insurance, if elected. To pay by EDS for your retiree term life insurance, call MetLife at 1-866-548-7139.

**Pension deduction:** I authorize the Department of Retirement Systems to deduct medical and dental premiums (if elected), retiree term life insurance (if elected), and applicable premium surcharges I am required to pay from my retirement pension. I understand that deductions are taken at the end of the month that you receive coverage. For example, if your coverage starts September 1, the deduction will be taken at the end of September.

**Invoicing:** I will pay my medical and dental premiums (if elected) and applicable premium surcharges monthly by check. I understand I will receive a separate bill from MetLife for my retiree term life insurance, if elected. I understand that I must make my first payment before I will be enrolled.



## 2022 PEBB Retiree Election 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 PEBB 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 PEBB health plan coverage 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 benefits.

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

I understand I am responsible for paying the applicable tobacco use premium surcharge and spouse or state-registered domestic partner coverage premium surcharge in addition to my monthly medical premiums (if I am not enrolled in Medicare Part A and Part B).

I understand if I enroll in PEBB retiree dental, it is my responsibility to call the plan (not my provider) to verify my dentist is covered by the dental plan network I selected.

I understand if I or any enrolled dependent are eligible for Medicare Part A and Part B, we must enroll and stay enrolled in Part A and Part B.

If I choose to defer medical/dental for myself, I cannot enroll my eligible dependents. I understand I can enroll or

reenroll **no later than 60 days** after losing other qualifying medical coverage or during the PEBB Program's annual open enrollment as long as I maintain and provide proof of continuous enrollment in one or more qualifying coverages. A gap in coverage of 31 days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of a qualifying coverage, as well as between each enrollment in qualifying coverages. The PEBB Program must receive my enrollment form no later than 60 days after other qualifying medical coverage ends, or no later than the last day of the PEBB Program's annual open enrollment.

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand the PEBB Program will direct a portion of my monthly premium to an HSA 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.

If I die, my eligible surviving dependents must complete the *PEBB Retiree Election Form* (form A) to enroll or defer enrollment in PEBB retiree insurance coverage. The PEBB Program must receive the form no later than 60 days after my death.

This form replaces all election or change forms previously submitted to the PEBB Program. If I am a retiree or survivor receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share my information with DRS to better serve me.

I understand that my enrollment and my dependents' enrollment are subject to my adherence to 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 insurance coverage selections being rejected or defaulted.

Please sign, date, and keep a copy for your records.

Subscriber's signature

Date

### Form return

Submit form and documentation using one of the methods below:

#### Mail to:

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


**Fax to:** 1-360-725-0771

**Electronically submit:** Send a secure online message to PEBB Customer Service by registering for an account on HCA's website at [hca.wa.gov/fuze-questions](https://hca.wa.gov/fuze-questions). Sign and date any forms you attach to a secure message. This option is separate from PEBB My Account.

## 2022 PEBB Retiree Election Form

Subscriber's last name

Social Security number

**2022 PEBB Program contractors**  Do not send forms to addresses below. They are 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**

1300 SW 27th Street  
Renton, WA 98057  
1-866-648-1928  
TTY: 1-800-833-6388

#### **Premiera Blue Cross**

PO Box 327  
Seattle, WA 98111  
1-800-817-3049  
TTY: 1-800-842-5357

#### **Uniform Medical Plan**, administered by Regence BlueShield (for medical benefit questions)

PO Box 2998  
Tacoma, WA 98401  
1-888-849-3681 (TRS: 711)

#### **Uniform Medical Plan**, administered by Washington State Rx Services (for prescription drug questions)

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

#### **UnitedHealthcare**

Customer Service Department  
PO Box 30770  
Salt Lake City, UT 84130-0770  
1-855-873-3268 (TRS: 711)

### Dental contractors

#### **DeltaCare**, administered by Delta Dental of Washington

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

#### **Willamette Dental of Washington, Inc.**

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

### Life insurance contractor

#### **Metropolitan Life Insurance Company (MetLife)**

MetLife Recordkeeping Center  
PO Box 14406  
Lexington, KY 40512  
(Plan #164995-1-G)  
1-866-548-7139

HCA is committed to providing equal access to our services. If you need an accommodation, please call the PEBB Program at 1-800-200-1004.

**HCA's Privacy Notice:** HCA will keep your information private as allowed by law. To see our Privacy Notice, go to HCA's website at [hca.wa.gov/pebb-retirees](https://hca.wa.gov/pebb-retirees).

Social Security number

## 11

## 2022 PEBB Retiree Election Form

Subscriber's last name

Social Security number

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

Part A (hospital)      Yes      No    If Yes, enter effective date from Medicare card:

Part B (medical)      Yes      No    If Yes, enter effective date from Medicare card:

If Yes, proof is required. Attach a copy of their entire entitlement letter or a copy of their Medicare card to this form if we don't already have a copy. Write your full name and the last four digits of your Social Security number on the copy. If your dependent is eligible for Medicare, they must enroll and stay enrolled in Part A and Part B to keep PEBB retiree health plan coverage.

They are in the process of enrolling in Medicare Part A and Part B. They will submit proof after they receive their entitlement letter or Medicare cards.

### Is this person enrolled in Medicare Part D (prescription drug coverage)?

Yes      No      If Yes, effective date:

If Yes, you may enroll only in Premera Blue Cross Medicare Supplement Plan G. If you want to enroll in any other PEBB medical plan, you must disenroll from the Part D plan.

### Is this person enrolled in Medicaid with Medicare Part D?

Yes      No      If Yes, effective date:

 The premium surcharges only apply to subscribers who are **not** enrolled in Medicare Part A and Part B.

### Tobacco use premium surcharge

Response required if you are enrolling a dependent age 13 or older in medical coverage. If you check Yes or do not check any boxes below, you will be charged the \$25 premium surcharge. See the *PEBB Premium Surcharge Attestation Help Sheet* available at [hca.wa.gov/pebb-retirees](https://hca.wa.gov/pebb-retirees) for instructions on how to respond.

### 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. 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 they have enrolled in or accessed one of the tobacco cessation resources noted in the *PEBB Premium Surcharge Attestation Help Sheet*.