

2009 COBRA Continuation Coverage Election Form for Premium Reduction

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
 - If you believe you qualify for a COBRA premium reduction under the American Recovery and Reinvestment Act and wish to apply for COBRA continuation coverage, you must complete and submit this form along with the *Request for Treatment as an Assistance Eligible Individual* form within **90 days** after receiving notice from the PEBB Program. **If you don't, you will lose your right to elect COBRA coverage.**
 - If you wish to change the medical plan or medical and dental plans you had as an employee, or your coverage options (from medical and dental coverage to medical-only coverage), you must note your change(s) in this form and submit it along with the *Request for Treatment as an Assistance Eligible Individual* form within **90 days** after receiving notice from the PEBB Program.
 - You may also use this form if you are making changes to an account that is currently receiving the COBRA premium subsidy.
 - **We must receive your first payment before you can be enrolled.** (Make checks payable to Washington State Treasurer.)
 - Attach appropriate dependent certification forms if required (spouse, students ages 20 through age 23, extended dependents, and dependents with disabilities).
 - If you have a child age 20-24 who is not a student, he or she may qualify for PEBB adult dependent coverage. (See the *Adult Dependent Enrollment/Change* form.)
 - If you receive a COBRA premium reduction and wish to cancel your COBRA coverage due to eligibility for other group health coverage or Medicare, do not complete this form. Complete and return the *Participant's Notice of Other Health Coverage* form.
- Forms are available at www.pebb.hca.wa.gov or by calling 1-800-200-1004.**

Employee Information ONLY	Employee name	Social security number
	Date employer coverage ended (mm/dd/yyyy)	Are you making changes to an existing account? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 1: SUBSCRIBER INFORMATION				
Social security number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Last name	First name	Middle initial
Address				Apt./unit number
City	State	ZIP Code	County of residence	
Date of birth (mm/dd/yyyy)	Work phone number (including area code) ()		Home phone number (including area code) ()	
Select coverage you wish to continue: <input type="checkbox"/> Medical and dental <input type="checkbox"/> Medical only <i>You cannot enroll in dental-only coverage to receive the COBRA premium reduction.</i>				
<input type="checkbox"/> Cancel all coverage Reason _____ Date of event _____				
You cannot be eligible for other group health coverage (such as through an employer or your spouse's employer) or Medicare to enroll in COBRA continuation coverage AND receive a COBRA premium reduction.				

Section 2: SPOUSE INFORMATION <i>If adding a spouse, attach a completed Spouse or Qualified Domestic Partner Certification form.</i>				
Social security number	Date of marriage	Last name	First name	Middle initial
Address (if different from subscriber)		City	State	ZIP Code
Date of birth (mm/dd/yyyy)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			
Select coverage you wish to continue: <input type="checkbox"/> Medical and dental <input type="checkbox"/> Medical only <i>You cannot enroll in dental-only coverage to receive the COBRA premium reduction.</i>				
<input type="checkbox"/> Cancel all coverage Reason _____ Date of event _____				
You cannot be eligible for other group health coverage (such as through an employer or your spouse's employer) or Medicare to enroll in COBRA continuation coverage AND receive a COBRA premium reduction.				

Section 3: FAMILY MEMBER INFORMATION *Use additional forms for more members. List only eligible family members you wish to enroll in COBRA continuation coverage who were also covered on your PEBB account when you lost your employer-sponsored health coverage.*

Relationship to subscriber	Social security number	<input type="checkbox"/> Disabled? <input type="checkbox"/> Student? <i>Check only if age 20 or older.</i>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)
Address (if different from subscriber)		City	State ZIP Code
Select coverage you wish to continue: <input type="checkbox"/> Medical and dental <input type="checkbox"/> Medical only <i>You cannot enroll in dental-only coverage to receive the COBRA premium reduction.</i>			
<input type="checkbox"/> Cancel all coverage Reason _____ Date of event _____			
You cannot be eligible for other group health coverage (such as through a parent's employer) or Medicare to enroll in COBRA continuation coverage AND receive a COBRA premium reduction.			

Section 4: CHANGES *Check all that apply. You must submit this form and any dependent forms within 60 days of the event.*

<input type="checkbox"/> Name	<input type="checkbox"/> Terminating a dependent's coverage due to death
<input type="checkbox"/> Address	<input type="checkbox"/> Terminating a dependent's coverage due to loss of eligibility for PEBB coverage
<input type="checkbox"/> Medical plan	<input type="checkbox"/> Other (explain) _____
<input type="checkbox"/> Dental plan	_____
<input type="checkbox"/> Adding newly acquired child(ren) due to birth, adoption, or placement for adoption	Date of event _____
<input type="checkbox"/> Adding a dependent due to a court order or medical support order (attach copy of court order or medical support order)	_____
<input type="checkbox"/> Terminating a dependent's coverage due to divorce or legal separation Provide former spouse's new address	_____
_____	_____

Section 5: MEDICAL PLAN SELECTION

*Check only one. If you choose a plan that differs from the plan you were enrolled in as an employee, the new plan must cost **the same or less than** your employee plan to qualify for the COBRA premium reduction. See the Reduced-Premium COBRA Monthly Rates for more information.*

- Aetna Public Employees Plan of Washington
- Group Health Cooperative
 - Group Health Classic
 - Group Health Value
- Kaiser Foundation Health Plan of the Northwest
 - Kaiser Permanente Classic
 - Kaiser Permanente Value
- Uniform Medical Plan

Section 6: DENTAL PLAN SELECTION

*Check only one. If you choose a plan that differs from the plan you were enrolled in as an employee, the new plan must cost **the same or less than** your employee plan to qualify for the COBRA premium reduction. See the Reduced-Premium COBRA Monthly Rates for more information.*

- Preferred Provider Organization
 - Uniform Dental Plan (Group #3000) (may receive services from any provider)
 - Managed Care Plans
 - DeltaCare, administered by Washington Dental Service (group #3100)
 - Dentist name _____ (must receive services from DeltaCare provider)
 - Willamette Dental of Washington, Inc.
 - Clinic location _____ (must receive services from Willamette Dental Group provider)
- Note:** Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

Section 7: SIGNATURE *Required*

I have received and read the information in the PEBB notice or the Continuation of Coverage Election Notice. By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or I do not update this information within the timelines in PEBB rules, I must repay any claims paid by my health plan(s). My family members and I may also lose PEBB benefits as of the last day of the month we qualified. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB benefits.

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

This form replaces all previous COBRA Continuation of Coverage Election Form for Premium Reduction I have submitted for PEBB benefits.

HCA's Privacy Notice:

We will keep your information private as allowed by law. To see our Privacy Notice, call 360-923-2822 or go to www.hca.wa.gov.

Subscriber's signature _____ Date _____

Please sign and date this form. Return to: Washington State Health Care Authority P.O. Box 42684, Olympia, WA 98504-2684 If payment enclosed, return to: Washington State Health Care Authority P.O. Box 42695, Olympia, WA 98504-2695

2009 PEBB MEDICAL CONTRACTORS

Aetna Public Employees Plan of Washington, P.O. Box 14089, Lexington, KY 40512-4089
1-800-222-9205 or TTY 1-800-628-3323

Group Health Cooperative, 320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-800-813-2000 or TTY 1-800-735-2900

Uniform Medical Plan, P.O. Box 34850, Seattle, WA 98124-1850
1-800-762-6004 or TTY 1-888-923-5622

2009 PEBB DENTAL CONTRACTORS

DeltaCare, administered by Washington Dental Service, 9706 Fourth Ave. NE, Seattle, WA 98115-2157
1-800-650-1583

Uniform Dental Plan, 9706 Fourth Ave. NE, Seattle, WA 98115-2157
1-800-537-3406

Willamette Dental of Washington, Inc., 6950 NE Campus Way, Hillsboro, OR 97124-5611
1-800-360-1909

Do Not Distribute