

## Participant's Notice of Other Health Coverage

- Complete this form if you currently receive a COBRA premium reduction and are **eligible** for other group health coverage or Medicare, *even if you do not enroll. This will notify the PEBB Program to cancel your COBRA premium reduction.* This does not apply to other health coverage that:
  - Provides only dental, vision, counseling, or referral services (or a combination of these); OR
  - Provides a health flexible spending account or on-site medical services maintained by the employer that are primarily for first aid or prevention/wellness care; OR
  - Has a pre-existing condition waiting period. *Once your waiting period has expired, you must complete and submit this form.*
- Type or print clearly in black ink.

Section 1: PARTICIPANT INFORMATION				
Social security number	Last name	First name	Middle initial	
Address				Apt./unit number
City	State	ZIP Code	Daytime telephone number (     )     -     -     -     -     -     -	Date of birth (mm/dd/yyyy)

Section 2: PREMIUM REDUCTION INELIGIBILITY INFORMATION
<input type="checkbox"/> I am eligible for coverage under another group health plan. <b>Date you became eligible</b> _____ <i>If any dependents receiving a COBRA premium reduction are also eligible for this group health coverage, list their names and information below.</i>
1. Dependent's name _____ Social security number _____ Birth date (mm/dd/yyyy) _____ Date (s)he became eligible (if different than above) _____
2. Dependent's name _____ Social security number _____ Birth date (mm/dd/yyyy) _____ Date (s)he became eligible (if different than above) _____
3. Dependent's name _____ Social security number _____ Birth date (mm/dd/yyyy) _____ Date (s)he became eligible (if different than above) _____
<input type="checkbox"/> I am eligible for Medicare. <b>Date you became eligible</b> _____ <i>If any dependents receiving a COBRA premium reduction are eligible for Medicare, list their names and information below.</i>
1. Dependent's name _____ Social security number _____ Birth date (mm/dd/yyyy) _____ Date (s)he became eligible (if different than above) _____
<p>If you fail to notify the PEBB Program of becoming eligible for other group health plan coverage or Medicare, and continue to receive a COBRA premium reduction, you may have to pay a fine of 110% of the amount of the COBRA premium reduction.</p> <p><b>Eligibility is determined regardless of whether you take or decline the other coverage.</b> However, eligibility for coverage does <b>not</b> include any time spent in a waiting period.</p>

Section 3: SIGNATURE <i>Required</i>
<p>To the best of my knowledge and belief, all of the information I have provided on this form is true and correct.</p> <p><b>HCA's Privacy Notice:</b> We will keep your information private as allowed by law. To see our Privacy Notice, call 360-923-2822 or go to <a href="http://www.hca.wa.gov">www.hca.wa.gov</a>.</p> <p>Participant's signature _____ Date _____</p>

Please sign and date this form.

Return to: Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684