Washington State Health Care Authority
Public Employees Benefits Board

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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 or dental plan(s) you had as an employee, or your coverage options (from medical and dental coverage to medical-only or dental-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.
- **We must receive your first payment before you can be enrolled.** (Make checks payable to Washington State Treasurer.)
- If you need to cancel your COBRA premium reduction because you became eligible 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 by calling the PEBB Program at 1-800-200-1004.

Employee Information ONLY	Date employer coverage ended (mm/dd/yyyy)	Name of last employing agency

Section 1: SUBSCRIBER INFORMATION

Social security number	Sex ❑ Male ❑ 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: ❑ Medical and dental ❑ Medical only ❑ Dental only

You are not eligible for the COBRA premium reduction if you are eligible for Medicare or other group health coverage (such as through an employer or your spouse's employer).

Section 2: SPOUSE INFORMATION

Your spouse must have been covered on your PEBB account when you lost your employer-sponsored health coverage.

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 ❑ Male ❑ Female	**Select coverage you wish to continue:** ❑ Medical and dental ❑ Medical only ❑ Dental only		

You are not eligible for the COBRA premium reduction if you are eligible for Medicare or other group health coverage (such as through an employer or your spouse's employer).

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	Last name	First name	Middle initial
Address (if different from subscriber)		City	State	ZIP Code
Date of birth (mm/dd/yyyy)	Sex ❑ Male ❑ Female	**Select coverage you wish to continue:** ❑ Medical and dental ❑ Medical only ❑ Dental only		

You are not eligible for the COBRA premium reduction if you are eligible for Medicare or other group health coverage (such as through a parent's employer).

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Section 4: 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.*	**Section 5: 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.*
❑ 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	**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 6: 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 forms 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