Clear form

# 2020 School Employee Enrollment Form

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

**Please use this form only if you are unable to use the online enrollment system, SEBB My Account.**

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

Inaccurate, incomplete, or illegible information may delay coverage. The information written on this form replaces all enrollment forms previously submitted.

To make changes during the annual open enrollment period, submit a new form, showing plan choices for yourself and each dependent. To make changes outside of the annual open enrollment period, go to SEBB My Account or submit the *SEBB School Employee Change Form* to your payroll or benefits office.

Benefits differ for employees whose eligibility was locally negotiated under WAC 182-30-130(6). See *Eligibility & enrollment* at **hca.wa.gov/sebb-employee** for details.

! Remember to read and sign section 6. To enroll children, complete section 8 on page 9.

## 1 Subscriber

Social Security number – – 

Date of birth (mm/dd/yyyy) / /

Last name

First name

Middle initial

Suffix

Birth sex (M/F)

Phone number – –

Work phone number – – 

Residential address

Address line 2

City

State

ZIP/Postal Code

County

Country

! If your address changes, you must give your new address to your payroll or benefits office no later than 60 days after you move.

Subscriber Social Security number ___ – ___ – ____

Mailing address (if different from previous page)

Mailing address line 2

City

State

ZIP/Postal Code

Country

Are you or your dependent(s) enrolling in SEBB insurance coverage under another account?

☐ **Yes** Please contact your payroll or benefits office for help with enrollment options related to dual enrollment.

☐ **No**

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

| Medical coverage | Dental coverage | Vision coverage |
|---|---|---|
| ☐ Cover | ☒ Cover | ☒ Cover |
| ☐ Waive | Dental cannot be waived. | Vision cannot be waived. |

You can waive SEBB medical coverage if you are enrolled in other employer-based group medical, a TRICARE plan, or Medicare. However, you must enroll in SEBB dental, vision, basic life and accidental death and dismemberment (AD&D) insurance, and, if applicable, basic long-term disability (LTD) insurance. If you waive medical coverage for yourself, you cannot enroll your dependents in SEBB medical coverage.

**Tobacco use premium surcharge**

If you check **Yes** to using a tobacco product or do not respond to this attestation, you will be charged a monthly $25-per-account tobacco use premium surcharge in addition to your monthly medical premium. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use.

For instructions on how to respond, see the *2020 SEBB Premium Surcharge Attestation Help Sheet* in the enrollment guide or at **hca.wa.gov/sebb-employee** under *Forms & publications*.

Does the **tobacco use premium surcharge** apply to you?

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

☐ **No**, I am not subject to the monthly $25 premium surcharge. I have not used tobacco products in the past two months, or I have enrolled in the tobacco cessation resources noted in the *2020 SEBB Premium Surcharge Attestation Help Sheet*.

Subscriber Social Security number ___ – ___ – ____

## 2 Spouse/State-registered domestic partner

**!** Skip this section if you are not enrolling a spouse or state-registered domestic partner, as defined by WAC 182-31-140, in medical, dental, or vision coverage. To enroll dependent children, please complete Section 8, located at the end of the form.

You must provide proof of your spouse or state-registered domestic partner's eligibility within the SEBB Program's timelines, or they will not be enrolled. A list of acceptable documents to verify eligibility is available in the enrollment guide or at **hca.wa.gov/sebb-employee**. Your spouse or state-registered domestic partner cannot be enrolled in two SEBB Program medical, dental, and vision accounts at the same time. If enrolling a state-registered domestic partner, also attach a completed *Declaration of Tax Status* form to indicate whether they qualify as a dependent for tax purposes under IRC Section 152, as modified by IRC Section 105(b).

Relationship to subscriber. Choose one.

☐ Spouse: date of marriage (mm/dd/yyyy): __ __ / __ __ / ____

☐ State-registered domestic partner: date registered (mm/dd/yyyy): __ __ / __ __ / ____

Social Security number ___ – ___ – ____

Date of birth (mm/dd/yyyy) __ __ / __ __ / ____

Last name

First name

Middle initial

Suffix

Birth sex (M/F)

Phone number ___ – ___ – ____

Work phone number ___ – ___ – ____

Residential address (if different from subscriber)

Address line 2

City

State

ZIP/Postal Code

County

Country

**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 |

Subscriber Social Security number ☐☐☐ – ☐☐ – ☐☐☐☐

**Tobacco use premium surcharge**
Response required if enrolling your spouse or state-registered domestic partner in medical coverage. If you check **Yes** or do not check any boxes below, you will be charged the monthly $25-per-account tobacco use premium surcharge in addition to your monthly medical premium.

The *2020 SEBB Premium Surcharge Attestation Help Sheet* and the *2020 SEBB Spousal Plan Calculator* are available at **hca.wa.gov/sebb-employee** under *Surcharges*.

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

☐ **Yes**, I am subject to the monthly $25 premium surcharge. My spouse or state-registered domestic partner has used tobacco products in the past two months.

☐ **No**, I am not subject to the monthly $25 premium surcharge. My spouse or state-registered domestic partner has not used tobacco products in the past two months, or they have enrolled in one of the tobacco cessation resources noted in the *2020 SEBB Premium Surcharge Attestation Help Sheet*.

**Spouse or state-registered domestic partner coverage premium surcharge**
Response required if enrolling your spouse or state-registered domestic partner in medical coverage. You will be charged a monthly $50 premium surcharge in addition to your monthly medical premium if you enroll your spouse or state-registered domestic partner in SEBB medical coverage and they have elected not to enroll in other employer-based group medical coverage that is comparable to the Public Employees Benefits Board (PEBB) Uniform Medical Plan (UMP) Classic plan. See the *2020 SEBB Premium Surcharge Attestation Help Sheet* for instructions on how to respond.

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

☐ **Yes**, I am subject to the $50 premium surcharge. I used the *2020 SEBB Premium Surcharge Attestation Help Sheet* and completed the *2020 SEBB Spousal Plan Calculator*.

If you check **Yes** or do not check any boxes below, you will be charged the monthly $50 spouse or state-registered domestic partner coverage premium surcharge in addition to your monthly medical premium.

☐ **No**, I am not subject to the $50 premium surcharge. I used the *2020 SEBB Premium Surcharge Attestation Help Sheet* and, if needed, completed the *2020 SEBB Spousal Plan Calculator*. Which questions, if any, on the *2020 SEBB Premium Surcharge Attestation Help Sheet* did you check **No**? Check all that apply.

☐ Question 2 ☐ Question 3 ☐ Question 4 ☐ Question 5 ☐ Question 6

☐ **Employer to determine if premium surcharge applies.** I used the *2020 SEBB Premium Surcharge Attestation Help Sheet* and am completing and submitting a printed *2020 SEBB Spousal Plan Calculator*. My employer will use these to determine whether my spouse's or state-registered domestic partner's employer-based group medical is comparable to the PEBB UMP Classic plan and whether I am subject to this premium surcharge.

Subscriber Social Security number ___ – ___ – ____

## 3 Medical plan selection

Choose one medical plan.*

- ☐ Kaiser Permanente NW 1
- ☐ Kaiser Permanente NW 2
- ☐ Kaiser Permanente NW 3
- ☐ Kaiser Permanente WA Core 1
- ☐ Kaiser Permanente WA Core 2
- ☐ Kaiser Permanente WA Core 3
- ☐ Kaiser Permanente WA SoundChoice[1]
- ☐ Kaiser Permanente WA Options Access PPO 1
- ☐ Kaiser Permanente WA Options Access PPO 2
- ☐ Kaiser Permanente WA Options Access PPO 3
- ☐ Premera High PPO
- ☐ Premera Peak Care EPO
- ☐ Premera Standard PPO
- ☐ UMP Achieve 1[2]
- ☐ UMP Achieve 2[2]
- ☐ UMP High Deductible[2]
- ☐ UMP Plus–Puget Sound High Value Network[2]
- ☐ UMP Plus–UW Medicine Accountable Care Network[2]

! Information about medical plan options can be found at **hca.wa.gov/sebb-employee** and in the enrollment guide. Contact the plans for benefits information. (Contact information is on page 8 of this form.) Before you enroll, make sure that the provider you want to use accepts the specific plan you choose.

* If you are eligible for the employer contribution toward SEBB benefits, but do not waive or enroll in SEBB Program medical coverage, you will be enrolled by default as a single subscriber in UMP Achieve 1 (administered by Regence BlueShield) as your medical plan, Uniform Dental Plan, MetLife vision insurance, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability (LTD) insurance. Your dependents will not be enrolled. You will be charged a monthly $33 premium for medical coverage as well as a $25-per-account monthly tobacco use premium surcharge.

These plans have specific service areas. All school employees are offered a selection of plans based on their county of residence. Some school employees, including employees who live outside Washington State, may have more plan options if they work in a district that crosses county lines or is in a county that borders Idaho or Oregon.

If you move out of the medical plan's service area or change jobs to a different district, charter school, or educational service district (represented employees only), you may need to change plans. 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.

[1] *Not all Kaiser Permanente contracted providers in Spokane County are in the SoundChoice network. Please make sure your provider is in-network before you visit.*

[2] *Administered by Regence BlueShield*

Subscriber Social Security number ☐☐☐ – ☐☐ – ☐☐☐☐

## 4 Dental plan selection

Choose one dental plan in this section. Before you enroll, make sure the provider you want to use accepts the specific plan and group you choose.

**Preferred Provider Organization (PPO)**

☐ **Uniform Dental Plan**, (Group #09600) administered by Delta Dental of Washington

**Managed-care plans**

☐ **DeltaCare**, (Group #09601) administered by Delta Dental of Washington. You will select and receive care from a primary care dental provider in the DeltaCare network. Before you enroll, call DeltaCare at 1-800-650-1583 to make sure that the provider you want to use accepts the specific plan you choose.

☐ **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 Plan. Before you enroll, call Willamette Dental at 1-855-433-6825 to make sure that the provider you want to use accepts the specific plan you choose.

## 5 Vision plan selection

Choose one vision plan in this section. Before you enroll, make sure the provider you want to use accepts the specific plan you choose.

☐ Davis Vision

☐ EyeMed Vision Care

☐ MetLife Vision

! Carrier contact information is on page 8.

### STOP! Important to note before you sign.

If you are eligible for the employer contribution toward SEBB benefits, but do not waive or enroll in SEBB Program medical coverage, you will be enrolled by default as a single subscriber in UMP Achieve 1 (administered by Regence BlueShield) as your medical plan, Uniform Dental Plan, MetLife vision insurance, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, and basic long-term disability (LTD) insurance. Your dependents will not be enrolled. You will be charged a monthly $33 premium for medical coverage as well as a $25-per-account monthly tobacco use premium surcharge.

Subscriber Social Security number ___ – ___ – ____

## 6 Signature

I declare that, by submitting this form, 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 plan(s) 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, or do not 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, denial of insurance benefits, and loss of my job.

If adding a state-registered domestic partner 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 of any dependent is not complete until the SEBB Program verifies the eligibility of my dependents. I understand that 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.

Eligible employees must enroll in SEBB dental, vision, basic life and accidental death and dismemberment, and basic long-term disability insurance*. Employees that elect 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 any applicable tobacco use premium surcharge and spouse or state-registered domestic partner 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.

*Not available to employees whose eligibility was locally negotiated under Washington Administrative Code (WAC) 182-30-130(6).

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

Subscriber's signature

Date (mm/dd/yyyy) __ / __ / ____

! Continue to Section 8 to add dependents.

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**.

Subscriber Social Security number ___ - ___ - ____

## 7 This section to be completed by a school district, charter school, or educational service district benefits administrator

HCA Code

Organization number

Organization name

Type of organization

- ☐ School district
- ☐ Charter school
- ☐ Educational service district

Eligibility: Check one

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

Eligibility date (mm/dd/yyyy) ___ / ___ / ____

Effective date (mm/dd/yyyy) ___ / ___ / ____

## 2020 SEBB Program contractors (for your reference)

### Medical contractors

**Kaiser Foundation Health Plan of the Northwest**
500 NE Multnomah St.,
Suite 100
Portland, OR 97232-2099
1-800-813-2000 (TTY: 711)

**Kaiser Foundation Health Plan of Washington**
601 Union St., Suite 3100
Seattle, WA 98101
1-888-901-4636
TTY: 1-800-833-6388 or 711

**Kaiser Foundation Health Plan of Washington Options, Inc.**
601 Union St., Suite 3100
Seattle, WA 98101
1-888-901-4636
TTY: 1-800-833-6388 or 711

**Premera Blue Cross**
7001 220th St SW
Mountlake Terrace, WA 98043
1-800-807-7310
TTY: 1-800-842-5357

**Uniform Medical Plan**
administered by Regence BlueShield (for medical benefit questions)
1800 Ninth Avenue, Suite 235
Seattle, WA 98101
1-800-628-3481 TRS: 711

**Uniform Medical Plan**
administered by Washington State Rx Services (for prescription drug questions)
PO Box 40168
Portland, OR 97240-0168
1-888-361-1611 (TRS: 711)

### Dental contractors

**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
1-800-537-3460
TTY: 800-833-6384

**Willamette Dental of Washington, Inc.**
6950 NE Campus Way
Hillsboro, OR 97124-5611
1-855-4DENTAL:
(1-855-433-6825)
TTY: 711

### Vision contractors

**Davis Vision**
Vision Care Processing Unit
PO Box 1525
Latham, NY 12110
1-877-377-9353
TTY: 1-800-523-2847

**EyeMed Vision Care**
4000 Luxottica Place
Mason, OH 45040
1-800-699-0993
TTY: 1-844-230-6498

**Metropolitan Life Insurance Company** (Vision Plan)
PO Box 385018
Birmingham, AL 35238-5018
1-855-MET-EYE1
(1-855-638-3931)
TTY: 1-800-428-4833

Subscriber Social Security number ___ – ___ – ____

## 8 Dependent(s) (as defined in WAC 182-31-140)

List eligible dependents you wish to enroll. Provide proof of each dependent's eligibility within the enrollment timelines or the dependent will not be enrolled. If enrolling an extended dependent, attach an *Extended Dependent Certification* form, a valid court order showing legal custody or guardianship, and a *Declaration of Tax Status* form. If enrolling a non-qualified tax dependent, attach a *Declaration of Tax Status* form. If enrolling a disabled dependent, complete a *Certification of a Child With a Disability* form and submit it as instructed on the form, unless you meet an exception outlined in the *School Employee Initial Enrollment Guide*.

Relationship to subscriber

- ☐ Child
- ☐ Stepchild (not legally adopted)
- ☐ Extended dependent (court order needed)
- ☐ Disabled dependent (age 26 or older)

! Dependents cannot be enrolled in two SEBB medical, dental, and vision accounts. Refer to the enrollment guide or **hca.wa.gov/sebb-employee** for information and a list of verification documents.

Social Security number ___ – ___ – ____ Date of birth (mm/dd/yyyy) __ / __ / ____

Last name

First name | Middle initial | Suffix | Birth sex (M/F)

Residential address (if different from subscriber)

Address line 2

City | State

ZIP/Postal Code | County

Country

**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 |

**Tobacco use premium surcharge**

Response required for dependents age 13 and older being enrolled in medical coverage.
If you check **Yes** or do not check any boxes below, you will be charged the monthly $25-per-account tobacco use premium surcharge in addition to your monthly medical premium.

Does the **tobacco use premium surcharge** apply to this dependent?

- ☐ **Yes**, I am subject to the monthly $25 premium surcharge. My dependent has used tobacco products in the past two months.
- ☐ **No**, I am not subject to the monthly $25 premium surcharge. My dependent 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 *2020 SEBB Premium Surcharge Attestation Help Sheet*.

Subscriber Social Security number ___ – ___ – ____

## 8 Dependent(s) (as defined in WAC 182-31-140)

List eligible dependents you wish to enroll. Provide proof of each dependent's eligibility within the enrollment timelines or the dependent will not be enrolled. If enrolling an extended dependent, attach an *Extended Dependent Certification* form, a valid court order showing legal custody or guardianship, and a *Declaration of Tax Status* form. If enrolling a non-qualified tax dependent, attach a *Declaration of Tax Status* form. If enrolling a disabled dependent, complete a *Certification of a Child With a Disability* form and submit it as instructed on the form, unless you meet an exception outlined in the *School Employee Initial Enrollment Guide*.

Relationship to subscriber

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Social Security number ___ – ___ – ____

Date of birth (mm/dd/yyyy) __ / __ / ____

Last name

First name | Middle initial | Suffix | Birth sex (M/F)

Residential address (if different from subscriber)

Address line 2

City | State

ZIP/Postal Code | County

Country

**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 |

**Tobacco use premium surcharge**

Response required for dependents age 13 and older being enrolled in medical coverage.
If you check **Yes** or do not check any boxes below, you will be charged the monthly $25-per-account tobacco use premium surcharge in addition to your monthly medical premium.

Does the **tobacco use premium surcharge** apply to this dependent?

- ☐ **Yes**, I am subject to the monthly $25 premium surcharge. My dependent has used tobacco products in the past two months.
- ☐ **No**, I am not subject to the monthly $25 premium surcharge. My dependent 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 *2020 SEBB Premium Surcharge Attestation Help Sheet*.

! Use additional forms to list more dependents.