



**Section 3: Family Member Information** (such as child, grandchild, etc.)

List all **eligible** family members and indicate their enrollment status; family members cannot be enrolled in any other PEBB coverage. **Use additional forms for more members.** Please attach appropriate **dependent certification** form, if required.

<b>A</b>	<b>Relationship to subscriber</b>	<input type="checkbox"/> Disabled? (Check only if age 20 or older.)	<input type="checkbox"/> Student?	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Social security number		Physician or clinic code (contact your plan for code)		
Last name		First name	Middle initial	Date of birth (mm/dd/yyyy)
Address (if different from subscriber)		City	State	Zip Code
Medical Coverage		<input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____ <i>If waiving, see Section 5.</i>		<input type="checkbox"/> Terminate Reason _____ Date Effective _____

  

<b>B</b>	<b>Relationship to subscriber</b>	<input type="checkbox"/> Disabled? (Check only if age 20 or older.)	<input type="checkbox"/> Student?	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Social security number		Physician or clinic code (contact your plan for code)		
Last name		First name	Middle initial	Date of birth (mm/dd/yyyy)
Address (if different from subscriber)		City	State	Zip Code
Medical Coverage		<input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____ <i>If waiving, see Section 5.</i>		<input type="checkbox"/> Terminate Reason _____ Date Effective _____

  

<b>C</b>	<b>Relationship to subscriber</b>	<input type="checkbox"/> Disabled? (Check only if age 20 or older.)	<input type="checkbox"/> Student?	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Social security number		Physician or clinic code (contact your plan for code)		
Last name		First name	Middle initial	Date of birth (mm/dd/yyyy)
Address (if different from subscriber)		City	State	Zip Code
Medical Coverage		<input type="checkbox"/> Enroll <input type="checkbox"/> Waive: date effective _____ <i>If waiving, see Section 5.</i>		<input type="checkbox"/> Terminate Reason _____ Date Effective _____

**Section 4: Medical Plan Selection** (check only one)

- Community Health Plan of Washington\*
- Group Health Cooperative\*
- Group Health Options, Inc.\*
- Uniform Medical Plan PPO

\*These plans require the physician or clinic code of your selected primary care provider. **Contact the plan for code or go online to [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov) for provider directory.**

**Section 5: Signature**

<b>REQUIRED</b>	<p>I declare that my family members and I are eligible for the coverage requested. I authorize my employer to deduct from my earnings any premium I am required to pay for the coverage I have selected. I understand that I may be subject to dismissal and/or repayment of any claims paid by my health plan or premiums paid by my employer if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines. A deposit of premium does not guarantee coverage and will be refunded if I am determined by the Washington State Health Care Authority to be ineligible for coverage.</p> <p>I declare that I or any family members, who have chosen to waive medical coverage, as indicated above, currently have other continuous, comprehensive group medical insurance. I understand that proof of continuous, comprehensive group medical coverage will be required to re-enroll family members in a PEBB plan outside of an open enrollment period. Application for re-enrollment must be made within 60 days of losing other coverage. This form supercedes all forms and submissions I have previously made for PEBB coverage.</p> <p>Washington State law may require disclosure of any information I submit as public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at <a href="http://www.hca.wa.gov">www.hca.wa.gov</a>.</p> <p>Subscriber's signature _____ Date _____</p>
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**Please sign and date this form. Return the completed form to HR (PE07).**