Subscriber's last name

Social Security number

3 Dependents

List dependents you wish to enroll or remove from coverage. They must be eligible under PEBB Program rules. This includes children through the month of their 26th birthday regardless of marital status, student status, or eligibility for coverage under another plan and children age 26 or older with a disability. Use additional forms for more dependents.

If enrolling a dependent, you must provide proof of their eligibility within the PEBB Program's enrollment timelines or they will not be enrolled. Timelines and a list of documents we will accept to verify eligibility are available at **hca.wa.gov/pebb-employee**.

If enrolling a state-registered domestic partner's child, also attach a *PEBB Declaration of Tax Status* to indicate whether they qualify as a dependent for tax purposes. A health plan change is not allowed when adding an SRDP's child if they are not a tax dependent.

If enrolling an extended dependent, also attach a *PEBB Extended Dependent Certification*.

If enrolling a child with a disability age 26 or older, also attach a *PEBB Certification of a Dependent Child with a Disability* and return as instructed on the form.

Relationship to subscriber

- Child
- Stepchild (not legally adopted)
- Extended dependent (attach copy of court order)
- Child with a disability age 26 or older

⚠ If they are eligible to enroll in both the PEBB and SEBB Programs, they are limited to a single enrollment in medical, dental, and vision from either the PEBB Program or SEBB Program as described in 182-12-123. They may not enroll in both programs.

Social Security number

Date of birth

Sex assigned at birth[1]
Male Female

Last name

Gender identity[2]
Male Female X

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address (if different from subscriber)

Address line 2

City

State

ZIP/Postal code

County

1 This field is required for health care services.

2 Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit HCA's website at **hca.wa.gov/gender-x**

2025 PEBB Employee Enrollment/Change form

Subscriber's last name

Social Security number

Choose one box for each type of coverage.

Medical coverage	Dental coverage	Vision coverage
☐ Cover	☐ Cover	☐ Cover
☐ Remove from medical	☐ Remove from dental	☐ Remove from vision

If removing from coverage, include reason:

Tobacco use premium surcharge

Response required if you are enrolling dependents age 13 and older in medical coverage. If you check Yes or do not check any boxes below, you will be charged the $25-per-account premium surcharge in addition to your monthly medical premium. See page 2 of this form for instructions on how to respond. If this is a change to a previous attestation, submit the *PEBB Premium Surcharge Attestation Change Form*.

Does the tobacco use premium surcharge apply to this dependent? Check one:

☐ Yes, I am subject to the $25 premium surcharge. This dependent has used tobacco products in the past two months.

☐ No, I am not subject to the $25 premium surcharge. This dependent has not used tobacco products in the past two months or has enrolled in or accessed one of the tobacco cessation resources listed in the *PEBB Employee Enrollment Guide*.

Subscriber's last name

Social Security number

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2025 PEBB Employee Enrollment/Change form

Subscriber's last name

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