

# 2024 SEBB Premium Surcharge Attestation Change Form

Use this form to report a change that affects your premium surcharge for tobacco use or spouse or state-registered domestic partner (SRDP). State-registered domestic partner is defined in Washington Administrative Code 182-31-020.

Changes that result in a premium surcharge will be effective the first day of the month after the date of the status change. If that day is the first of the month, the change to the surcharge begins on that day. Changes that result in removing a premium surcharge will begin the first day of the month after your attestation is received. If that day is the first of the month, the change to the surcharge begins on that day. **Exception:** If you are required to attest to the spouse or SRDP coverage premium surcharge during the SEBB Program's annual open enrollment, any changes will be effective January 1 of the following year. Type or print clearly in black ink. Example: **J O H N**

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## Tobacco use premium surcharge

**⚠ Skip this section, if you are not reporting a change to tobacco use for you or a dependent.**

A \$25-per-account premium surcharge is required in addition to your monthly medical premium if you or a dependent (age 13 and older) enrolled on your SEBB medical plan uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months. It does not include the religious or ceremonial use of tobacco. **Tobacco products means** any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products.

Tobacco products do not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids, such as over-the-counter nicotine replacement products, and prescription nicotine replacement products.

### Events that require a change:

You must change your tobacco use attestation when you or a dependent's tobacco use status changes, such as quitting or starting smoking.

### The premium surcharge will not apply if:

- You and all enrolled dependents ages 18 and older who use tobacco products are currently enrolled in the free tobacco cessation program through your medical plan (visit HCA's website at [hca.wa.gov/tobacco-free-sebb](https://hca.wa.gov/tobacco-free-sebb)).
- All enrolled dependents ages 13 to 17 who use tobacco products have accessed resources at [teen.smokefree.gov](https://teen.smokefree.gov).

### Does this premium surcharge apply to you?

List yourself and each dependent age 13 and older enrolled on your SEBB medical coverage. You **do not** have to attest for dependents ages 12 and younger. You do not need to attest when the dependent turns age 13 unless the dependent uses, or starts using, tobacco products.

Answer **No** for you and each enrolled dependent who has never used tobacco products, has stopped using them for the past two months, is currently enrolled in their medical plan's tobacco cessation program (if age 18 or older), or has accessed information at [teen.smokefree.gov](https://teen.smokefree.gov) (if age 13 to 17). If you or your dependents have never used tobacco products, you do not need to provide a date.

If you check **Yes** or leave the checkboxes blank for yourself or any enrolled dependent age 13 or older, you will be charged the \$25 tobacco use premium surcharge in addition to your monthly medical premium.

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Subscriber's last name

Social Security number

## Subscriber

Last name

Middle initial

First name

Social Security number

### Have you used tobacco products in the past two months?

Yes No Date tobacco use status changed

## Dependent 1

Last name

Middle initial

First name

Last four digits of Social Security number

### Has this dependent used tobacco products in the past two months?

Yes No Date tobacco use status changed

## Dependent 2

Last name

Middle initial

First name

Last four digits of Social Security number

### Has this dependent used tobacco products in the past two months?

Yes No Date tobacco use status changed

## Dependent 3

Last name

Middle initial

First name

Last four digits of Social Security number

### Has this dependent used tobacco products in the past two months?

Yes No Date tobacco use status changed



To attest for more dependents, copy this page.


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### Spouse or state-registered domestic partner coverage premium surcharge

 Skip this section if you do not have a spouse or SRDP enrolled on your SEBB medical plan.

A \$50 premium surcharge will be required in addition to your monthly medical premium if you enroll a spouse or SRDP, and they have chosen not to enroll in another employer-based group medical that is comparable to the Public Employees Benefits Board (PEBB) Program's Uniform Medical Plan (UMP) Classic. The comparison must be to PEBB UMP Classic, even if you are not enrolled in that plan.

#### Events that require a change:

You must attest to this premium surcharge:

- If you get a letter from the SEBB Program notifying you to attest during the SEBB Program's annual open enrollment.
- **No later than 60 days** after the date your spouse's or SRDP's employer-based group medical status changes.

See "Surcharges" on HCA's website at [hca.wa.gov/erb](https://hca.wa.gov/erb) to learn about these situations.

#### Answer Yes or No to Questions 2 through 6:

Question 1 does not apply. You must also check the corresponding boxes on your enrollment form.

<b>1</b>	Are you covering your spouse or SRDP in a SEBB medical plan under your account in 2024?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
<b>2</b>	Will they be eligible for medical coverage through their employer in 2024? (If they will not be employed in 2024, answer No.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>3</b>	Will their employer offer at least one medical plan that serves their county of residence in 2024?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>4</b>	Have they chosen not to enroll in their employer's medical (including PEBB) coverage in 2024?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>5</b>	Will the coverage offered by their employer in 2024 <b>not</b> be through the SEBB Program or a TRICARE plan? <ul style="list-style-type: none"><li>• Answer Yes if their employer <b>does not</b> offer SEBB coverage or a TRICARE plan.</li><li>• Answer No if their employer <b>offers</b> SEBB coverage or a TRICARE plan.</li></ul>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>6</b>	Will their share of the medical premium through their employer be less than \$117.81 per month in 2024?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered **No** to any of these questions, check No below. You will not be charged the surcharge.

If you answered **Yes** to all these questions, you must complete the steps below to find out if you will be charged the premium surcharge.

1. Your spouse or SRDP should ask their employer for a 2024 Summary of Benefits and Coverage (SBC) for all medical plans that:
  - a. Serve their county of residence.
  - b. Have a monthly premium of less than \$117.81 per month for the employee.
2. Use the SBC information to answer the questions in the *SEBB Spousal Plan Calculator* online tool on HCA's website at [hca.wa.gov/erb](https://hca.wa.gov/erb). Or you can download a paper version and submit it with your enrollment form, or with this form.


If using the online *SEBB Spousal Plan Calculator*, you will get a Yes or No response to whether the premium surcharge applies to you. Enter this response below.

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Social Security number

### Does this premium surcharge apply to you?

 If you enroll a spouse or SRDP on your SEBB medical plan and you check Yes or leave the checkboxes below blank, you will be charged the \$50 premium surcharge.

**Yes,** am subject to the \$50 premium surcharge. I used the *SEBB Spousal Plan Calculator* online. Provide the date your spouse's or SRDP's employer-based group medical status changed.

**No,** am not subject to the \$50 premium surcharge. I completed the *SEBB Spousal Plan Calculator* online. Provide the date your spouse's or SRDP's employer-based group medical status changed:

**Required.** Which questions above did you check No? Check all that apply. Question 1 is not applicable.

Question 2

Question 3

Question 4

Question 5

Question 6

My employer (for employees) or SEBB Program (for SEBB Continuation Coverage subscribers) to help determine if the premium surcharge applies. I am submitting a printed *SEBB Spousal Plan Calculator* to help determine if my spouse's or SRDP's employer-based group medical is comparable to PEBB's UMP Classic, and if I am subject to this premium surcharge.

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### Signature

By submitting this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not provide timely, updated information, I will owe surcharges to the SEBB Program. I declare that one (or more) of the events above occurred that requires me to change my attestation to the one or both premium surcharges, and that I am reporting it within the SEBB Program's deadlines. I am replacing all attestations previously submitted. I understand that changes that result in a premium surcharge will begin the first day of the month after the status change. If that day is the first of the month, the change to the surcharge begins on that day. I understand that changes that result in removing a premium surcharge will begin the first day of the month after receipt of the attestation. If that day is the first of the month, the change to the surcharge begins on that day.

I understand if I am providing an attestation to the spouse or state-registered domestic partner coverage premium surcharge during the SEBB Program's annual open enrollment, any changes become effective January of the following year. If I pay my monthly premiums by electronic debit service, I authorize the Health Care Authority to deduct any premium surcharges owed from these accounts.


Subscriber's last name

Last four digits of subscriber's Social Security number

Subscriber's signature

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### Form return

 Please return this form to your payroll or benefits office (employees) or the SEBB Program (for SEBB Continuation Coverage subscribers only).

#### Employees:

Your payroll or benefits office.

#### SEBB Continuation Coverage subscribers:

**Secure message:** Send us a secure message through HCA Support at [support.hca.wa.gov](https://support.hca.wa.gov), a secure website that allows you to log into your own account to communicate with us. You will need to set up a SecureAccess Washington (SAW) account to use this option.

**Mail to:** SEBB Program  
Washington State Health Care Authority  
PO Box 42720  
Olympia, WA 98504-2720

**Fax to:** 360-725-0771

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please contact the following. Employees: Your payroll or benefits office. SEBB Continuation Coverage members: The SEBB Program at 1-800-200-1004 (TRS: 711).

**HCA Privacy Notice:** HCA will keep your information private as allowed by law. To see our Privacy Notice, go to HCA's website at [hca.wa.gov/erb](https://hca.wa.gov/erb).