Washington State Health Care Authority
Public Employees Benefits Board

Premium Surcharge Attestation Form

Submit this form no later than **31 days** (for employees) or **60 days** (for all other subscribers who need to attest) from the date you become eligible for benefits to report whether the tobacco use and spouse or domestic partner coverage premium surcharges apply to you.

Section 1: Tobacco use premium surcharge

See details on *Attestations Worksheet*: Step One.

A monthly $25-per-account surcharge will be required in addition to your premium if you or a family member on your PEBB medical coverage uses a tobacco product. If you and all family members who use tobacco products are enrolled in your PEBB medical plan's tobacco cessation program, the surcharge will not apply.

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.

Type or print clearly in black ink. List yourself and each family member you enroll on your PEBB medical coverage. (To add more family members, attach additional copies of this form.)					Has this person used tobacco products in the last two months?	
					Yes	**No** Or he or she is enrolled in our PEBB medical plan's tobacco cessation program.
You:	First name	Middle initial	Last name	Last four digits of Social Security number	☐	☐
Family member:	First name	Middle initial	Last name		☐	☐
Family member:	First name	Middle initial	Last name		☐	☐
Family member:	First name	Middle initial	Last name		☐	☐
Family member:	First name	Middle initial	Last name		☐	☐
Family member:	First name	Middle initial	Last name		☐	☐
Family member:	First name	Middle initial	Last name		☐	☐
Family member:	First name	Middle initial	Last name		☐	☐
Family member:	First name	Middle initial	Last name		☐	☐
Family member:	First name	Middle initial	Last name		☐	☐
Family member:	First name	Middle initial	Last name		☐	☐
Family member:	First name	Middle initial	Last name		☐	☐

If you checked "YES" or left the checkboxes blank for yourself or any family member(s) listed above, you will pay the monthly $25 surcharge.

Section 2: Spouse or domestic partner coverage premium surcharge

Complete this only if you enroll a spouse or domestic partner on your PEBB medical coverage.

A $50-per-month surcharge will be required in addition to your premium if you have a spouse or domestic partner enrolled on your PEBB medical coverage, and your spouse or domestic partner has chosen not to enroll in medical coverage through his or her employer that is comparable to Uniform Medical Plan (UMP) Classic.

See if this surcharge applies to you on *Attestations Worksheet*: Step Two.

Does the spouse or domestic partner coverage surcharge apply to you?

☐ **Yes**
I used the *Attestations Worksheet*: Step Two, and completed the *Spousal Plan Calculator* online.

Find the *Spousal Plan Calculator* (electronic and paper versions) online at **www.hca.wa.gov/pebb** .

☐ **No**
I used the *Attestations Worksheet*: Step Two (and, if needed, completed the *Spousal Plan Calculator* online).

☐ **Employer or PEBB to determine**
I used the *Attestations Worksheet*: Step Two, and am completing and submitting a paper *Spousal Plan Calculator* sheet so my employer (for employees) or the PEBB Program (for all other subscribers) can determine whether my spouse's or partner's employer-based group medical insurance is comparable to UMP Classic.

If you enroll a spouse or domestic partner on your PEBB medical coverage and you check "YES" or leave this section blank, you will pay the monthly $50 surcharge.

Section 3: Signature

By signing 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 PEBB Program. This form replaces all *Premium Surcharge Attestation Forms* and electronic surcharge attestations previously submitted.

HCA's Privacy Notice: We will keep your information private as allowed by law. To see our Privacy Notice, go to **www.hca.wa.gov/pebb.**

Name (print) _____ Last four digits of Social Security number _____

Signature _____ Date _____

Agency name _____
(employees only)

Please sign and date this form.

If you're:	Return it to:
An employee	Your personnel, payroll, or benefits office.
Any other subscriber	PEBB Program Washington State Health Care Authority P.O. Box 42684 Olympia, WA 98504-2684 or fax to: 360-725-0771

Attach your paper Spousal Plan Calculator sheet (if needed).