

Request to Cancel Dependent Coverage

- Type or print clearly in black ink.
- List **ONLY** family members you wish to remove from your PEBB coverage.

Additional forms are available at www.pebb.hca.wa.gov or by calling PEBB Benefits Services at 1-800-200-1004.

Subscriber information ONLY	Last name	First name	Middle initial
	Social security number		Date of birth (mm/dd/yyyy)

SECTION 1: Family members to remove from PEBB coverage

List all family members who you wish to **remove** from PEBB coverage. Use additional forms for more family members.

A	Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)
B	Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)
C	Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)
D	Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

SECTION 2: Signature *Required*

I understand that if I complete and return this form to the PEBB Program by November 30, 2009, the PEBB Program will disenroll my listed family members effective December 31, 2009, and will confirm this date to me in writing.

Please note: If you are an employee who has paid for your ineligible dependents' premiums on a pre-tax basis (such as for a former spouse or a child who is no longer attending school), you may be responsible for paying taxes on the fair market value of those benefits. You can find the state's contribution for medical and dental coverage in the "Worksheet for Determining Dependent Status" section of the *Spouse or Qualified Domestic Partner Certification* form packet, found on PEBB's website at www.pebb.hca.wa.gov. Contact your tax advisor for details.

HCA's Privacy Notice: We will keep your information private as allowed by law. To see our Privacy Notice, call 360-923-2822 or go to www.hca.wa.gov.

Subscriber's signature _____ Date _____

Please sign and date this form, and return to: Washington State Health Care Authority
P.O. Box 42685
Olympia, WA 98504-2685

Or fax to: 360-923-2608