Washington State Health Care Authority
Public Employees Benefits Board

Clear Form

Certification of Dependent With a Disability

After turning age 26, your dependent may be eligible for enrollment under your Public Employees Benefits Board (PEBB) Program health plan coverage if:

- Your dependent's developmental disability or physical handicap occurred before age 26, and
- He or she is incapable of self-sustaining employment, and depends on you for support and ongoing care.

Initial Certification. *First-time certification of a currently enrolled dependent's disability status after he or she turns age 26, or first-time certification of a newly enrolled dependent with a disability who is age 26 or older.*

Employees	***Retirees, COBRA, Continuation Coverage, or Leave Without Pay (LWOP)***
Your completed *Employee Enrollment/Change* form **must be received** by your personnel, payroll, or benefits office, AND Your completed *Certification of Dependent With a Disability* form **must also be received** by the medical plan* you elected on your *Employee Enrollment/Change* form within the following timelines: • **New employees**. Within 31 days of becoming eligible for PEBB benefits. • **Current employees**. No later than: ▪ The last day of the PEBB Program's annual open enrollment period, or ▪ 60 days after a qualifying special open enrollment event. ***Medical plan contact information on the back of this form.***	Your completed *Election/Change* form **must be received** by the PEBB Program, AND Your completed *Certification of Dependent With a Disability* form **must also be received** by the medical plan* you elected on your *Election/Change* form within the following timelines: • **New retirees**. Within 60 days after your employer-paid or COBRA coverage ends. • **New COBRA or PEBB Continuation Coverage subscribers**. Within 60 days of the mailing date of the *PEBB Continuation of Coverage Election Notice* sent to you. • **Current retirees, COBRA, PEBB Continuation Coverage, and LWOP subscribers**. No later than: ▪ The last day of the PEBB Program's annual open enrollment period, or ▪ 60 days after a qualifying special open enrollment event. ***Medical plan contact information on the back of this form.***

Recertification. *Review of an employee, retiree, COBRA, PEBB Continuation Coverage, or LWOP subscriber's currently certified dependent when requested by the medical plan or PEBB Program.* This form **must be completed and received by your medical plan within the timeframe explained in the letter you received requesting the recertification**.

Instructions: Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage. Complete "Subscriber Information" and "Dependent Information" sections; your provider must complete the "Physician" section on the second page of this form.

Subscriber Information

Last name	First name	Middle Initial	Social Security number	
Address	Apt./unit number	City	State	ZIP Code
Mailing address (if different)	Apt./unit number	City	State	ZIP Code
Work phone number ( )	Home phone number ( )	Agency/Subagency		

Dependent Information

Last name	First name	Middle Initial	Social Security number

This is a(n) (check one):		Is dependent enrolled in Medicare? (If yes, attach copy of Medicare card or entitlement letter.)	Relationship to subscriber
☐ New enrollment	☐ Recertification	Part A (hospital) ☐ Yes ☐ No	☐ Daughter
☐ Enrollment at or after age 26	☐ Special open enrollment	Part B (medical) ☐ Yes ☐ No	☐ Son ☐ Legal extended dependent

Has this dependent ever been employed? ☐ Yes ☐ No If yes, list the employer name(s), address(es) and date(s) of employment:	Is this dependent currently employed? ☐ Yes ☐ No If yes, list the employer name(s), address(es), date(s) of employment, and hours worked:

(continued)

Certification of Dependent With a Disability

Subscriber's last name	First name	Middle Initial	Social Security number

Physician: Complete this section *The subscriber must pay any fees for completing this form.*			
Physician's last name	First name		MI
Mailing address	City	State	ZIP Code
Is this child chiefly dependent on the subscriber for support and ongoing care? ☐ Yes ☐ No If yes, please explain why under "Nature of disability" below.			
Has disability existed continuously since before age 26? ☐ Yes ☐ No If no, what date did disability first exist?			
Nature of disability, including diagnosis (please give as much detail as possible) Prognosis (please estimate duration of disability)			
I certify that, to the best of my knowledge and belief, the information I have provided is true and accurate. **Physician's signature** _____ **Date** _____			

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 update this information within the timelines in PEBB rules, to the extent permitted by federal and state law, I must repay any claims paid by my health plan or premiums paid on my dependent's behalf. To the extent permitted by law, the PEBB Program may retroactively terminate coverage for me and my dependents, if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, denial of PEBB benefits, and loss of my job. The PEBB Program will verify eligibility for me and my family members. I understand that the PEBB Program may ask for this verification at any time. However, the PEBB Program will verify the disability and dependency of adult dependents with a disability periodically, but not more frequently than annually after the two-year period following the dependent's 26th birthday. The PEBB Program may delegate verification of disability to the subscriber's health plan. This form replaces all previous *Certification of Dependent With a Disability* forms I have submitted for PEBB benefits.

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/public-employee-benefits**.

Subscriber's signature _____ **Date** _____

HCA is committed to providing equal access to our services. If you need accommodation, please call 1-800-200-1004 or 711 for relay services.

Subscriber: Complete and mail this form to your health plan (or PEBB for dental only) at the address below.

Kaiser Foundation Health Plan of Washington (formerly Group Health Cooperative) enrollees:	**Uniform Medical Plan** enrollees:	**Kaiser Foundation Health Plan of the Northwest** enrollees:	**Dental only** enrollees:
Kaiser Foundation Health Plan of Washington Clinical Review Unit PO Box 34589 Seattle, WA 98124 **Toll-free fax:** 1-800-377-8853 **Phone:** 1-800-289-1363 (Select option 2, then option 4.)	Regence BlueShield M/S BU231 333 Gilkey Road Burlington, WA 98233 **Toll-free fax:** 1-855-639-3940 **Phone:** 1-888-849-3681	Kaiser Foundation Health Plan of the Northwest Attn: Client Services Unit, Membership Administration 500 NE Multnomah, Suite 100 Portland, OR 97232-2099 **Fax:** 503-813-3109 **Phone:** 503-813-3613	PEBB Program Health Care Authority PO Box 42684 Olympia, WA 98504-2684 **Fax:** 360-725-0771 **Phone:** 1-800-200-1004