

Extended Dependent Certification

Guidelines for Extended Dependent Approval

To be considered for enrollment in Public Employees Benefits Board (PEBB) Program coverage as an extended dependent, the following conditions must be met:

- The extended dependent cannot be your child through birth, adoption, marriage, or a state-registered domestic partnership.
- You, your spouse, or your state-registered domestic partner are the legal guardian or have legal custody of the child.
- The child's official residence is with the guardian or custodian.
- You have provided the PEBB Program with a valid court order showing that you, your spouse, or your state-registered domestic partner have legal custody or guardianship.
- The child is not a foster child unless you, your spouse, or your state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption.

The PEBB Program will determine eligibility using the information you submit on this form and the legal documents you submit with it.

The table below shows you how to certify or recertify an extended dependent. The Extended Dependent Certification form begins on the next page.

Initial Certification <i>If you're applying for a first-time certification of an extended dependent:</i>	
Employees	Retirees or continuation coverage subscribers
Submit ALL of the following: Your completed <i>Employee Enrollment/Change</i> form AND This completed <i>Extended Dependent Certification</i> form AND A copy of a valid court order showing legal custody or guardianship. Your personnel, payroll, or benefits office must receive these within the following timelines: <ul style="list-style-type: none"> • New employees. No later than 31 days after becoming eligible for PEBB benefits. • Current employees. No later than: <ul style="list-style-type: none"> ▪ The last day of the PEBB Program's annual open enrollment (November 30) OR ▪ 60 days after a qualifying special open enrollment event. For a list of qualifying events, see the <i>Change your coverage</i> page at www.hca.wa.gov/pebb-employee. Search for "<i>special open enrollment</i>." 	Submit ALL of the following: Your completed election form or change form AND This completed <i>Extended Dependent Certification</i> form AND A copy of a valid court order showing legal custody or guardianship. The PEBB Program must receive these within the following timelines: <ul style="list-style-type: none"> • New retirees. No later than 60 days after your employer-paid, COBRA, or continuation coverage ends. • Elected and full-time appointed officials. No later than 60 days after the date you leave public office. • New continuation coverage subscribers. No later than 60 days from the postmark date on the <i>PEBB Continuation of Coverage Election Notice</i> sent to you. • Current retirees and continuation coverage subscribers. No later than: <ul style="list-style-type: none"> ▪ The last day of the PEBB Program's annual open enrollment (November 30) OR ▪ 60 days after a qualifying special open enrollment event. For a list of qualifying events, see the <i>Change your coverage</i> page at www.hca.wa.gov/pebb-retiree. Search for "<i>special open enrollment</i>."
Recertification <i>The PEBB Program reviews the eligibility of extended dependent children annually. However, the PEBB Program reserves the right to review an extended dependent child's eligibility at any time. The PEBB Program must receive this completed form no later than 30 days from the date on the letter you received from the PEBB Program requesting the recertification.</i>	

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Extended Dependent Certification *(continued)*

Subscriber's last name	First name	Middle initial	Social Security number
Dependent child's last name	First name	Middle initial	Social Security number

Type or print clearly in dark ink. Inaccurate, incomplete, or illegible information may delay coverage.

If the answer to the following question is "Yes," the child does not qualify for coverage as an extended dependent.	
Note: If this extended dependent is a foster child for which you or your spouse/state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption, then this form is not required.	
Is this extended dependent a foster child?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Subscriber Information				<input type="checkbox"/> New enrollment <input type="checkbox"/> Recertification	
Last name	First name	Middle initial	Social Security number		
Street address	Apt./unit number	City	State	ZIP Code	
Mailing address (if different)	Apt./unit number	City	State	ZIP Code	
Home phone number ()	Alternate phone number ()				

Dependent Child Information					
Relationship to subscriber	Last name	First name	Middle initial		
Child's Social Security number	Date of birth (mm/dd/yyyy)		<input type="checkbox"/> Female	<input type="checkbox"/> Male	
Is this child disabled? <i>Check only if age 26 or older.</i> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, also complete the <i>Certification of a Child With a Disability</i> form and submit to the address on the form.	Is the child's official residence with the guardian or custodian? <input type="checkbox"/> Yes: When did the child begin living with subscriber? (mm/dd/yyyy) _____ <input type="checkbox"/> No: Who does the child live with? Name _____ Address _____ _____				

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Extended Dependent Certification *(continued)*

Subscriber's last name	First name	Middle initial	Social Security number
Dependent child's last name	First name	Middle initial	Social Security number

Important notes

- You must provide a copy of valid court documents granting legal custody, guardianship, or temporary guardianship with this form.
- Make a copy of the completed form for your records.
- If this is a new enrollment, attach this form to your completed enrollment form.
- If this child's status as your extended dependent changes at any time after you submit this form, you must submit written notice **no later than 60 days** after the date your child is no longer eligible. Employees must notify their personnel, payroll, or benefits office; all others must notify the PEBB Program.

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 PEBB Program's required timelines, I must repay any claims paid by my health plan(s) or premiums paid on my dependent's behalf, to the extent permitted by federal and state law. My dependent may also lose PEBB benefits as of the last day of the month they were eligible. To the extent permitted by law, the PEBB Program may retroactively terminate coverage for my dependent if I materially misrepresent eligibility, or do not pay premiums and applicable premium surcharges 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 my dependents. I understand that the PEBB Program may ask for this verification at any time and that I must submit recertification forms and documents so they are received by the PEBB Program within the required timeline.

This form replaces all *Extended Dependent Certification* forms previously submitted for PEBB benefits.

Subscriber's signature _____ Date _____

Mail or fax your completed forms and documentation, if required, to:

Mail:
Health Care Authority
PEBB Program
PO Box 42684
Olympia, WA 98504-2684

Fax:
360-725-0771

Do you have questions?

Employees:

Contact your personnel, payroll, or benefits office

Retirees and continuation coverage subscribers:

Call the PEBB Program at 1-800-200-1004 (TRS: 711) and select menu option 5.

HCA's privacy notice

We keep your information private except as allowed by law.
To see our privacy notice, go to www.hca.wa.gov.