Washington State Health Care Authority
Public Employees Benefits Board

Clear Form

Extended Dependent Certification

Guidelines for Extended Dependent Approval

An extended dependent is a child who is not your child through birth, adoption, marriage, or a registered domestic partnership. Some examples of extended dependents include, but are not limited to, a grandchild, niece, or nephew for whom you, your spouse, or registered domestic partner are the legal guardian or have legal custody.
The following guidelines determine if the child you want to enroll qualifies as an extended dependent:

1. The child's official residence must be with the guardian or custodian;
2. You must provide a court order signed by a judge or an officer of the court showing that you have legal custody, guardianship, or temporary guardianship; and
3. The child cannot be a foster child for whom support payments are made to you through the Department of Social and Health Services (DSHS) foster care program.

The child is not eligible for coverage as an extended dependent if the above requirements are not met. If these guidelines are met, the child may be eligible; however, the Health Care Authority (HCA) will determine eligibility using the information you submit on this form and the legal documents you submit with this form.

Type or print clearly in black ink. We cannot accept inaccurate, incomplete, or unreadable information.

If the answer to the following question is "Yes," the child does not qualify for coverage as an extended dependent.	
Is anyone receiving payment under the Washington State Department of Social and Health Services' (DSHS) foster care program for this child?	❑ Yes ❑ No

Subscriber Information				Agency/Sub agency		❑ New enrollment ❑ Recertification
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 ( )			

Dependent Child Information

I request to cover this child under: ❑ Medical ❑ Dental

Life insurance (attach a completed *Life and AD&D Insurance Enrollment/Change Form* if not currently enrolled):
❑ Basic Life Insurance ❑ Supplemental AD&D Insurance

Relationship to subscriber	Last name	First name	Middle initial
Social Security number	Date of birth (mm/dd/yyyy)	❑ Female	❑ Male

Disabled? *Check only if age 26 or older.*
❑ **Yes** ❑ **No**

If yes, also complete the *Certification of Dependent With a Disability* form and submit to the address on the form.

Is the child's official residence with the guardian or custodian?

❑ **Yes** When did the child begin living with subscriber? (mm/dd/yyyy) _____

❑ **No** Who does the child live with?

Name_____

Address _____

_____

(continued)

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

If the child's status as your extended dependent changes at any time after you submit this form, you must notify:
Employees: Your personnel, payroll, or benefits office
All other members: PEBB Program

You must provide with this application a copy of court documents granting legal custody, guardianship, or temporary guardianship signed by a judge or an officer of the court.

- **Please make a copy of the completed form for your records.**
- **If this is a new enrollment, attach this form to your completed Enrollment Election/Change form.**

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 Public Employees Benefits Board (PEBB) rules, to the extent permitted by federal and state law, I must repay any claims paid by my health plan(s) or premiums paid on my dependent's behalf. My dependent may also lose PEBB benefits as of the last day of the month he or she qualified. To the extent permitted by law, PEBB may retroactively cancel coverage for my dependent if I materially 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 my family members. I understand that the PEBB Program may ask for this verification at any time.

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

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

Subscriber's signature _____ **Date** _____

Questions? Call the PEBB Program at 1-800-200-1004.

Mail completed form and documentation to:

PEBB Program
Washington State Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684

or fax to: 360-725-0771