2021 SEBB Certification of a Child with a Disability

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

A Guidelines for certification of a child with a disability

After turning age 26, your child may be eligible for enrollment in your School Employees Benefits Board (SEBB) health plan coverage if:

- Your child's developmental or physical disability occurred before age 26, and
- They are incapable of self-sustaining employment and chiefly dependent upon you for support and ongoing care.

B Initial certification instructions

First-time certification is required for:

- A currently enrolled child's disability status after they turn age 26, or
- A newly enrolled child with a disability who is age 26 or older.

Employees

Enroll through SEBB My Account at **myaccount.hca.wa.gov**, or submit your completed *School Employee Enrollment* form to your payroll or benefits office. Send this certification form to the medical plan you chose to enroll in (or to the SEBB Program, if only enrolling the child in dental and/or vision coverage). Address information is on the next page. The forms must be received within the timelines described below:

Newly eligible employees: No later than 31 days after becoming eligible for SEBB Program benefits.

Currently eligible employees: No later than the last day of the SEBB Program's annual open enrollment, or 60 days after a qualifying special open enrollment event. See **hca.wa.gov/sebb-employee** under *Change your coverage* for a list of qualifying events.

Currently enrolled child turning age 26: No later than 60 days after the child with a disability turns age 26.

SEBB Continuation Coverage (COBRA or Unpaid Leave) subscribers only

Complete and submit your *Continuation Coverage Election/Change* form to the SEBB Program. Send this certification form to the medical plan you chose to enroll in (or to the SEBB Program, if the child is enrolling only in dental and/or vision coverage). Address information is on the next page. The forms must be received within the timelines described below:

Current continuation coverage subscribers: No later than the last day of the SEBB Program's annual open enrollment, or 60 days after a qualifying special open enrollment event. See **hca.wa.gov/sebb-continuation** under *Change your coverage* for a list of qualifying events.

Currently enrolled child turning age 26: No later than 60 days after the child with a disability turns age 26.

C Recertification instructions

If your child with a disability is enrolled and is being recertified

Your medical plan or the SEBB Program periodically requests review of your currently enrolled child's disability status following a previous certification. Your medical plan (or the SEBB Program if the child is enrolled only in dental and/or vision coverage) must receive this completed certification form **by the child's scheduled SEBB health plan coverage termination date**. This date is listed in the letter mailed to you about the recertification.

D To return this form

Mail or fax this form to your medical plan (or the SEBB Program if the child is only enrolled in dental and/or vision) at the address below.

Kaiser Foundation Health Plan of the Northwest

Kaiser Foundation Health Plan of the Northwest
Attn: Client Services Unit, Membership Administration
500 NE Multnomah Street, Suite 100
Portland, OR 97232-2099
Fax: 503-813-3109
Phone: 503-813-3613

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc.

Kaiser Foundation Health Plan of Washington
Clinical Review Unit
PO Box 34589
Seattle, WA 98124
Fax: 1-800-377-8853
Phone: 1-800-289-1363

Premera Blue Cross

Premera Blue Cross
MS 137
PO Box 327
Seattle, WA 98111

Uniform Medical Plan

Regence BlueShield
M/S BU231
333 Gilkey Road
Burlington, WA 98233
Fax: 1-855-639-3940
Phone: 1-888-849-3681

Enrollees in dental and/or vision only

SEBB Program
Health Care Authority
PO Box 42720
Olympia, WA 98504-2720

Clear form

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Type or print clearly in dark ink and use all capital lettering in the spaces provided.
Example: J O H N
Inaccurate, incomplete, or illegible information may delay coverage. Complete the "Subscriber information" and "Child information" sections. **Your child's provider must complete the "Provider" section on page 5.**

1 Subscriber information

Last name

Social Security number

First name

Middle initial

Suffix

Phone number

Alternate phone number

Street address

Address line 2

City

State

ZIP/Postal code

County

Mailing address (if different)

Mailing address line 2

City

State

ZIP/Postal code

Country

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format or language, please contact the following. **Employees:** Contact your payroll or benefits office. **SEBB Continuation Coverage members:** Call us at 1-800-200-1004 (TRS: 711).

2021 SEBB Certification of a Child with a Disability

Subscriber's last name

Social Security number

2 Child information

Last name

Social Security Number

First name

Middle initial

Suffix

This is a(n)

- New enrollment upon initial eligibility
- Enrollment at age 26
- Annual open enrollment change
- Recertification
- Special open enrollment change

What coverage is the child with a disability enrolled or enrolling in? (Check all that apply.)

- Medical
- Dental
- Vision

Is the child enrolled in Medicare? (If **yes**, attach a copy of the Medicare card or entitlement letter.)

Part A (hospital) Yes No

Part B (medical) Yes No

Relationship to subscriber

Child Stepchild Extended dependent (validated by a court order)

Has this child ever been employed? Yes No

If **yes**, list all of the employer names, addresses, and dates of employment:

Is this child currently employed? Yes No

If **yes**, list all of the employer names, addresses, dates of employment, and hours worked:

3 Signature

By submitting 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 SEBB Program's required timelines, I must repay any claims paid by my health plan(s) or premiums paid on my child's behalf to the extent permitted by federal and state laws. My child may also lose SEBB benefits as of the last day of the month they were eligible. To the extent permitted by law, the SEBB Program may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not pay premiums and applicable premium surcharges when due. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of benefits.

The SEBB Program will verify eligibility for my dependent. I understand that the SEBB Program may ask for this verification at any time. However, the SEBB Program will verify the disability and dependency for a child with a disability periodically, but not more than annually after the two-year period following the dependent's 26th birthday. My health plan may provide input; however, the SEBB Program performs the certification of eligibility.

This form replaces all previous *Certification of a Child with a Disability* forms I have submitted for SEBB benefits. I understand I must notify the SEBB Program in writing **no later than 60 days** after the last day of the month my child is no longer eligible as a child with a disability.

Subscriber's signature

Date (mm/dd/yyyy)

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Subscriber's last name

Social Security number

4 Provider to complete

This section must be completed by the child's provider. The subscriber must pay any fees for completing this form.

Last name

First name

Middle initial

Suffix

National Provider Identifier (NPI) number

Mailing address

Mailing address line 2

City

State

ZIP/Postal code

County

Is this child chiefly dependent on the subscriber for support and ongoing care? Yes No

If **yes**, please explain why under "Nature and level of disability" below.

Has the disability existed continuously since before age 26? Yes No

If **no**, what date did the disability first exist? (mm/dd/yyyy)

Nature and level of disability, including diagnosis with ICD Code (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 correct.

Provider's signature

Date (mm/dd/yyyy)