2021 SEBB Extended Dependent Certification

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

A Guidelines for extended dependent approval

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

- The extended dependent must not 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 extended dependent's official residence is with the guardian or custodian.
- You have provided the SEBB Program with a valid court order showing that you, your spouse, or your state-registered domestic partner have legal custody or guardianship.
- The extended dependent 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 SEBB Program will determine eligibility using the information you submit on this form and the legal documents you submit with it. Follow the instructions below to certify or recertify an extended dependent. The form begins on page 3.

B Initial certification instructions

Employees

Submit this certification form, a *School Employee Enrollment* form or *School Employee Change* form, and a copy of a valid court order showing legal custody or guardianship via SEBB My Account at **myaccount.hca.wa.gov** (preferred), or submit to your payroll or benefits office.

SEBB My Account (or your payroll or benefits office) must receive these within the following timelines:

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

Current employees: No later than the last day of the SEBB Program's annual open enrollment, or 60 days after a qualifying event creates a special open enrollment. For a list of these events, see *Change your coverage* on the SEBB webpages at **hca.wa.gov/sebb-employee**. Search for "special open enrollment."

SEBB Continuation Coverage (COBRA or unpaid leave) subscribers *only*

Submit this certification form, the *SEBB Continuation Coverage Election/Change* form, and a copy of a valid court order showing legal custody or guardianship to the SEBB Program at the address on the form.

The SEBB Program must receive these within the following timelines:

Current SEBB Continuation Coverage subscribers: No later than the last day of the SEBB Program's annual open enrollment, or 60 days after a qualifying event creates a special open enrollment. For a list of these events, see *Change your coverage* on the HCA website at **hca.wa.gov/erb**. Search for "special open enrollment."

C Recertification instructions

If your extended dependent is enrolled and is being recertified

Recertification is when the SEBB Program checks whether a currently enrolled extended dependent is still eligible under your SEBB coverage. The SEBB Program reviews the eligibility of enrolled extended dependents annually. However, we reserve the right to review an extended dependent's eligibility at any time.

The SEBB Program must receive this completed form **no later than 30 days** from the date on the recertification reminder letter we mailed to you. You are required to recertify your extended dependent as requested, regardless of whether you receive the recertification reminder letter.

D Important notes

- You must provide a copy of valid court documents granting legal custody, guardianship, or temporary guardianship with this certification form.
- If this is an initial certification, submit this form and a copy of the valid court order with your completed SEBB enrollment or change form. Submit documents as instructed below (or upload into SEBB My Account).
- Make a copy of the forms for your records.
- 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** from the last day of the month your child is no longer eligible. Employees must notify their payroll or benefits office. All others must notify the SEBB Program.

E To return this form

For initial certifications

Employees: Return your forms and any required documentation to your payroll or benefits office (or upload in SEBB My Account at **hca.wa.gov/sebb-employee**).

SEBB Continuation Coverage (COBRA and Unpaid Leave): Mail or fax your forms and any required documentation to the SEBB Program. See contact info below.

For recertifications

Mail or fax your forms and any required documentation to:
Health Care Authority
SEBB Program
PO Box 42720
Olympia, WA 98504-2720
Fax: 360-725-0771

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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.

Is this extended dependent a foster child?

☐ Yes ☐ No

If you answered **Yes**, has the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner assumed a legal obligation for total or partial support in anticipation of adoption of the child?

☐ Yes ☐ No

If the answer to the first question was **Yes**, and the answer to the second question was **No**, the child does not qualify for coverage as an extended dependent.

What kind of certification is this?

☐ New enrollment ☐ Recertification

1 Subscriber information

Social Security number

Last name

First name | Middle initial | Suffix

Phone number | Alternate phone number

Street address

Address line 2

City | State

ZIP/Postal code | Country

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 the Health Care Authority at 1-800-200-1004 (TRS: 711).

2021 SEBB Extended Dependent Certification

Subscriber's last name

Subscriber's Social Security number

2 Extended dependent child information

Social Security number

Date of birth (mm/dd/yyyy)

Sex assigned at birth[1]

☐ Male ☐ Female

Last name

Gender identity

☐ Male ☐ Female ☐ X[2]

First name

Middle initial

Suffix

Relationship to subscriber:

If this child is age 26 or older, does this child have a disability? ☐ Yes ☐ No

❗ If **Yes**, also complete the *SEBB Certification of a Child With a Disability* form (available at **hca.wa.gov/sebb-employee**) and upload the form to SEBB My Account or submit it to the address on the form.

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

☐ Yes. If **Yes**, when did the child begin living with the subscriber?

☐ No. If **No**, who does the child live with?

Last name, first name

Street address

City

State

ZIP/Postal code

Country

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 dependent's behalf, to the extent permitted by federal and state law. My dependent may also lose SEBB health plan coverage 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 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, and denial of SEBB benefits.

The SEBB Program will verify eligibility for my dependents. I understand that the SEBB Program may ask for this verification at any time and that I must submit recertification forms and documents so the SEBB Program receives them within the required timelines.

This form replaces all *SEBB Extended Dependent Certification* forms submitted in the past.

Subscriber's signature

Date (mm/dd/yyyy)

1 This field is required for health care services.

*2 Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit **hca.wa.gov/gender-x**.*