2021 PEBB Extended Dependent Certification

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

A Guidelines for extended dependent approval

To be considered for enrollment in Public Employees Benefits Board (PEBB) 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 PEBB 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 PEBB 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 *PEBB Employee Enrollment/Change* form, and a copy of a valid court order showing legal custody or guardianship to your payroll or benefits office. Your payroll or benefits office must receive these within the following timelines:

- **Newly eligible employees:** No later than 31 days after becoming eligible for PEBB benefits.
- **Current employees:** No later than the last day of the PEBB 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* at **hca.wa.gov/pebb-employee**. Search for "special open enrollment."

Retirees or PEBB Continuation Coverage subscribers only

Submit this certification form, the appropriate PEBB election or change form, and a copy of a valid court order showing legal custody or guardianship. The PEBB Program must receive these within the following timelines. Use the same address or fax as indicated in Section E below.

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

C Recertification instructions

If your extended dependent is enrolled and is being recertified

Recertification is when the PEBB Program checks whether a currently enrolled extended dependent is still eligible under your PEBB coverage. The PEBB 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 PEBB Program must receive this certification form **no later than 30 days** from the date on the recertification letter 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 a valid court order granting legal custody, guardianship, or temporary guardianship with this certification form.
- If this is an initial certification, submit this form and a copy of a valid court order with your completed *PEBB Enrollment/Change* form. Submit documents as instructed below..
- 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 PEBB Program.

E To return this form

For initial certifications

Employees: Submit this form and any required documents to your payroll or benefits office.

Retirees or PEBB Continuation Coverage subscribers (COBRA, and Unpaid Leave): Mail or fax your forms and any required documents to the PEBB Program. See contact info below.

For recertifications

Mail or fax your forms and any required documentation to:
Health Care Authority
PEBB Program
PO Box 42684
Olympia, WA 98504-2684
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. **Retirees and PEBB Continuation Coverage subscribers**: Call the PEBB Program at 1-800-200-1004 (TRS: 711).

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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 *PEBB Certification of a Child With a Disability* form (available at **hca.wa.gov/erb**) and 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?(mm/dd/yyyy)

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 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 health plan coverage 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 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 benefits.

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 the PEBB Program receives them within the required timelines.

This form replaces all *PEBB 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**.*