Clear Form

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Certification of a Child with a Disability

After turning age 26, your child may be eligible for enrollment under your Public Employees Benefits Board (PEBB) health plan if:

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

Initial Certification

First-time certification of a currently enrolled child's disability status after they turn age 26, or first-time certification of a newly enrolled child with a disability who is age 26 or older.

Employees

Your completed *Employee Enrollment/Change* form **must be received** by your personnel, payroll, or benefits office,
AND
Your completed *Certification of a Child with a Disability* form **must also be received** by the medical plan* you elected on your *Employee Enrollment/Change* form. Your medical plan will provide input to the PEBB Program. This form must be received as described below:

- **New 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 special open enrollment event. See **www.hca.wa.gov/erb** for a list of qualifying events.
- Currently enrolled child turning 26. No later than 60 days from the last day of the month in which the child turns age 26.

Note: Dental-only subscribers must submit this form to the PEBB Program. The timelines listed above apply.
**Medical plan contact information on the back of this form.*

Retirees or *continuation coverage subscribers*

Your completed *Election/Change* form **must be received** by the PEBB Program,
AND
Your completed *Certification of a Child with a Disability* form **must also be received** by the medical plan* you elected on your *Election/Change* form. Your medical plan will provide input to the PEBB Program. The forms must be received as described below:

- **New retirees.** No later than 60 days after your employer-paid, COBRA or continuation coverage ends. For elected or full-time appointed officials, no later than 60 days after you leave public office.
- **New continuation coverage subscribers.** No later than 60 days from the postmark date on the *PEBB Continuation Coverage Election Notice* sent to you.
- **Current retirees or continuation coverage subscribers.** No later than:
  - The last day of the PEBB Program's annual open enrollment, or
  - 60 days after a qualifying special open enrollment event. See **www.hca.wa.gov/erb** for a list of qualifying events.
- **Currently enrolled child turning 26.** No later than 60 days from the last day of the month in which the child turns age 26.

Note: Dental-only subscribers must submit this form to the PEBB Program. The timelines listed above apply.
**Medical plan contact information on the back of this form.*

Recertification

Review of an employee, retiree, or continuation coverage subscriber's currently certified child when requested by the medical plan or PEBB Program. This form **must be completed and received by your medical plan (or the PEBB Program if dental only) within the timeframe explained in the letter you received requesting the recertification.**

Instructions: Type or print clearly in dark ink. Inaccurate, incomplete, or illegible information may delay coverage. Complete "Subscriber Information" and "Dependent Information" sections; your provider must complete the "Physician" section on the second page of this form.

Subscriber Information

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 ( )			

Child Information

Last name	First name	Middle initial	Social Security number

This is a(n) (check one):	Is the child enrolled in Medicare? (If yes, attach copy of Medicare card or entitlement letter.)	Relationship to subscriber
☐ New enrollment ☐ Recertification ☐ Enrollment at age 26 ☐ Special open enrollment ☐ Annual open enrollment	Part A (hospital) ☐ Yes ☐ No Part B (medical) ☐ Yes ☐ No	☐ Child ☐ Stepchild ☐ Extended dependent (validated by a court order)

(continued)

Certification of a Child With a Disability

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

Has this child ever been employed? ☐ Yes ☐ No If yes, list the employer name(s), address(es) and date(s) of employment:	Is this child currently employed? ☐ Yes ☐ No If yes, list the employer name(s), address(es), date(s) of employment, and hours worked:

Physician: Complete this section *The subscriber must pay any fees for completing this form.*

Physician's last name	First name	MI

Mailing address	City	State	ZIP Code

Is this child chiefly dependent on the subscriber for support and ongoing care? ☐ Yes ☐ No
If yes, please explain why under "Nature of disability" below.

Has disability existed continuously since before age 26? ☐ Yes ☐ No If no, what date did disability first exist?

Nature of disability, including diagnosis (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 accurate.

Physician's signature _____ **Date** _____

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 PEBB rules, to the extent permitted by federal and state law, I must repay any claims paid by my health plan or premiums paid on my child's behalf. 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 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 me and my dependent(s). I understand that the PEBB Program may ask for this verification at any time. However, the PEBB Program will verify the disability and dependency for a child with a disability periodically, but not more frequently than annually after the two-year period following the dependent's 26th birthday. The subscriber's health plan may provide input; however, the PEBB Program performs the certification of eligibility. This form replaces all previous *Certification of a Child with a Disability* forms I have submitted for PEBB benefits. You must notify the PEBB Program in writing **no later than 60 days** after the date your child is no longer eligible as a child with a disability.

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

Subscriber's signature _____ Date _____

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format or language, please call 1-800-200-1004 (TRS: 711).

Subscriber: Complete and mail this form to your health plan (or PEBB for dental only) at the address on the next page.

Certification of a Child With a Disability

Kaiser Foundation Health Plan of Washington enrollees:	**Uniform Medical Plan** enrollees:	**Kaiser Foundation Health Plan of the Northwest** enrollees:	**Dental-only** enrollees:
Kaiser Foundation Health Plan of Washington Clinical Review Unit PO Box 34589 Seattle, WA 98124 **Toll-free fax:** 1-800-377-8853 **Phone:** 1-800-289-1363	Regence BlueShield M/S BU231 333 Gilkey Road Burlington, WA 98233 **Toll-free fax:** 1-855-639-3940 **Phone:** 1-888-849-3681	Kaiser Foundation Health Plan of the Northwest Attn: Client Services Unit, Membership Administration 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099 **Fax:** 503-813-3109 **Phone:** 503-813-3613	PEBB Program Health Care Authority PO Box 42684 Olympia, WA 98504-2684 **Fax:** 360-725-0771 **Phone:** 1-800-200-1004