SEBB Certification of a Child With a Disability

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

After turning age 26, your child may be eligible for enrollment under your School Employees Benefits Board (SEBB) Program health plan 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 maintenance.

Initial Certification (for enrollment starting January 1, 2020 or later)

Use this form if you're applying for a 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 — eligible for the employer contribution toward SEBB bene its

Enroll through SEBB My Account, or send your completed *School Employee Enrollment Form* to your payroll or benefits office. Your completed *Certification of a Child With a Disability* form must also be received by the medical plan* you elected on your *School Employee Enrollment Form*. Your medical plan will provide input to the SEBB Program. This form must be received as 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** for a list of qualifying events.
- **Currently enrolled child turning age 26**
  No later than 60 days after the disabled dependent turns age 26.

Continuation coverage (COBRA or Unpaid Leave) subscribers — not eligible for the employer contribution toward SEBB benefits

Your completed *Continuation Coverage Election/ Change* form must be received by the SEBB 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 SEBB Program. The forms must be received as described below:

- **New continuation coverage subscribers**
  No later than 60 days from the postmark date on the *SEBB Continuation Coverage Election Notice sent to* you.
- **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-employee** for a list of qualifying events.
- **Currently enrolled child turning 26**
  No later than 60 days after the disabled dependent turns age 26.

Note: If your dependent is only enrolling in dental and/or vision coverage, submit this form to the SEBB Program at the address noted on this form. The timelines listed above apply.

*Medical plan contact information is on the last page of this form.

Clear form

Recertification (after a child has been initially certified)

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

Instructions: Type or print clearly in dark ink in the spaces provided. Example: J O H N

Inaccurate, incomplete, or illegible information may delay coverage. Complete "Subscriber Information" and "Dependent Information" sections. Your provider must complete the "Physician" section (Section 3).

1 Subscriber Information

Social Security number – – Date of birth (mm/dd/yyyy) / /

Last name

First name | Middle initial | Suffix | Birth sex (M/F)

Phone number – – Alternate phone number – –

Residential address

Address line 2

City | State

ZIP/Postal Code

Mailing address (if different than residential)

Address line 2

City | State

ZIP/Postal Code

2 Child Information

Social Security number

Date of birth (mm/dd/yyyy)

Last name

First name

Middle initial

Suffix

Birth sex (M/F)

This is a(n):

- ☐ New enrollment
- ☐ Enrollment at age 26
- ☐ Annual open enrollment
- ☐ Recertification
- ☐ Special open enrollment

Is the child enrolled in Medicare? (If yes, attach a copy of 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 the employer's 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:

(continued)

3 Physician: Complete this section

The subscriber must pay any fees for completing this form.

Physician's Last name

Physician's First name

Middle initial

National Provider Identifier (NPI) number

Mailing address (if different than residential)

Address line 2

City

State

ZIP/Postal Code

Is this child chiefly dependent on the subscriber for support and ongoing care?

- ☐ Yes
- ☐ No

If yes, please explain under "Nature of disability" below.

Has disability existed continuously since before age 26?

- ☐ Yes
- ☐ No

If no, what date did the disability first exist?

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.

Physician's signature

Date

/ /

(continued)

4 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. 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 SEBB benefits, and loss of my job.

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 frequently than annually after the two-year period following the dependent's 26th birthday. The subscriber's health plan may provide input; however, the SEBB Program performs the certification of eligibility.

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

Subscriber signature

Date

/ /

! Subscriber: Complete and mail this form to your medical plan (or SEBB Program if you are only enrolled in dental and/or vision coverage) at the address on the next page.

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: Your payroll or benefits office. SEBB Continuation Coverage members: The Health Care Authority at 1-800-200-1004 (TRS: 711).

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

(continued)

Kaiser Foundation Health Plan of the Northwest enrollees:

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 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

Kaiser Foundation Health Plan of Washington Options, Inc. enrollees:

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

Premera Blue Cross enrollees:

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

Uniform Medical Plan enrollees:

Regence BlueShield
M/S BU231
333 Gilkey Road
Burlington, WA 98233
Toll-free 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