Extended Dependent Certification

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

To be considered for enrollment in School Employees Benefits Board (SEBB) Program 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 child'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 child 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. The table below shows how to certify or recertify an extended dependent. The *Extended Dependent Certification* form begins on the next page.

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

If you're applying for a first-time certification of an extended dependent.

Employees — eligible for the employer contribution toward SEBB benefits

Submit ALL of the following documents to your payroll or benefits office (or upload via SEBB My Account at myaccount.hca.wa.gov):

- Your completed School Employee Enrollment Form or School Employee Change Form; AND
- This completed Extended Dependent Certification form; AND
- A copy of a valid court order showing legal custody or guardianship.

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

- Current employees who want to enroll an extended dependent during the first annual open enrollment (October 1 through November 15, 2019): No later than the last day of the SEBB Program's first annual open enrollment;
- Employees who become benefits-eligible during or after the first annual open enrollment: No later than 31 days after becoming eligible for SEBB benefits or the end of open enrollment whichever is later. (Employees who are eligible to enroll on October 1, 2019 are not considered newly eligible.)
- Employees who have a qualifying special open enrollment event after the first annual open enrollment: **No later than 60 days** after a qualifying special open enrollment event. For a list of qualifying events, see Change your coverage at **hca.wa.gov/sebb-employee**. Search for "special open enrollment."

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

Submit ALL of the following documents to the SEBB Program at the address on the form:

- Your completed *SEBB Continuation Coverage Election/ Change* form; AND
- This completed *Extended Dependent Certification* form; AND
- A copy of a valid, current court order showing legal custody or guardianship.

The SEBB Program must receive these within the following timelines:

- New continuation coverage enrollees (enrolled January 1, 2020 or later): **No later than 60 days** from the postmark date on the *SEBB Continuation Coverage Election Notice* sent to you, or **no later than 60 days** from the date the school employee's SEBB health plan coverage ended. Sixty days from January 1, 2020, if you qualify under WAC 182-31-091.
- Current SEBB continuation coverage subscribers (enrolled January 1, 2020 or later): **No later than**:
  - **The last day of the SEBB Program's annual open enrollment**; OR
  - **60 days after** a qualifying special open enrollment event. For a list of qualifying events, see Change your coverage at **hca.wa.gov/sebb-employee**. Search for "special open enrollment."

Recertification (effective after January 1, 2020)

Recertification is when the SEBB Program verifies continued eligibility for an extended dependent who is already enrolled under your SEBB coverage. The SEBB Program reviews the eligibility of currently enrolled extended dependent children annually. However, the SEBB Program reserves the right to review an extended dependent child'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 that the SEBB Program will mail to you. You are required to recertify your extended dependent every 12 months, regardless of whether you receive the recertification reminder letter.

Type or print clearly in dark ink. Example: J O H N. Inaccurate, incomplete, or illegible information may delay coverage.

Subscriber's Social Security number

___ – __ – ____

Subscriber's last name

Subscriber's first name Middle initial

Dependent's Social Security number

___ – __ – ____

Dependent's last name

Dependent's first name Middle initial

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.

New enrollment/recertification (January 1, 2020 or later)

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 Dependent Child Information

Relationship to subscriber:

Social Security number

Date of birth (mm/dd/yyyy)

Last name

First name

Middle initial

Suffix

Birth sex (M/F)

If the child is age 26 or older, does this child have a disability?

- **Yes**
- No

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

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

- **Yes**:
  When did the child start living with subscriber? (mm/dd/yyyy)
- **No**: Who does the child live with?

Last name

First name

Residential address

Address line 2

City

State

ZIP/Postal Code

Important notes

- You must provide a copy of valid court documents granting legal custody, guardianship, or temporary guardianship with this form.
- Make a copy of the completed form for your records.
- If this is a new enrollment, attach this form to your completed enrollment form (or upload into SEBB My Account) and copy of a valid court order and submit as instructed on page 1 of this form.
- If this child's status as your extended dependent changes at any time after you submit this form, you must submit written notice to your payroll or benefits office (if you're an employee) or the SEBB Program (if you're a Continuation Coverage subscriber) **no later than 60 days** after the date your child is no longer eligible.

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 laws. My dependent 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 and that I must submit recertification forms and documents so they are received by the SEBB Program within the required timelines.

This form replaces all *Extended Dependent Certification* forms I have previously submitted for SEBB benefits.

Subscriber signature

Date

/ /

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

Continuation coverage subscribers
Mail or fax your completed forms and documentation, if required, to:
SEBB Program
Health Care Authority
PO Box 42720
Olympia, WA 98504-2720

Fax: 360-725-0771

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.**