PEBB Extended Dependent Certification

HCA | Health Care Authority
Public Employees Benefits Board

A Guidelines for extended dependent approval

To be eligible for Public Employees Benefits Board (PEBB) Program health plan coverage as an extended dependent, the following conditions must be met:

- The extended dependent is not your child through birth, adoption, marriage, or a state-registered domestic partnership.
- The extended dependent's official residence is with the legal guardian or custodian.
- You submit a copy of a valid court order showing that you or your spouse or state-registered domestic partner (SRDP) have legal custody or guardianship.
- The extended dependent is not a foster child unless you or your spouse or SRDP 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. 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.

Follow the instructions below to certify or recertify an extended dependent. The form begins on page 2.

B First-time certification instructions

Include this form and a copy of a valid court order showing legal custody or guardianship when you enroll. You can enroll online through Benefits 24/7 at **benefits247.hca.wa.gov** (preferred) or using a PEBB election/change form.

Forms must be received within the timelines described below:

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

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 the date you leave public office.

PEBB Continuation Coverage (Employer Group Ended Participation) subscribers
No later than 60 days after your employer group ended participation.

New continuation coverage subscribers
No later than 60 days from the date your PEBB health plan coverage ends or from the postmark date on the *PEBB Continuation Coverage Election Notice* sent to you, whichever is later.

Currently enrolled 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.

C Recertification instructions

If your extended dependent is enrolled and must recertify

The PEBB Program must receive this completed certification form **by the due date** listed in the recertification request letter mailed to you. You must 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 form.
- Make a copy of the forms for your records.

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Type or print clearly in dark ink and use all capital letters in the spaces provided. Example: J O H N
Inaccurate, incomplete, or illegible information may delay coverage.

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

County

Mailing address (if different)

Mailing address line 2

City

State

ZIP/Postal code

County

2 Extended dependent 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:

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 the HCA website at ***hca.wa.gov/gender-x***.

Extended dependent information (continued)

Is this extended dependent a foster child?

Yes No

If **yes**, have you or your spouse or SRDP 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 Recertificatio

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 on the HCA website at **hca.wa.gov/erb**) and submit it to the address on the form.

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

Yes If yes, when did the child begin living with you (the subscriber)?

(mm/dd/yyyy)

No If no, who does the child live with?

Last name

First name

Street address

Address line 2

City State

ZIP/Postal code County

Subscriber's last name

Social Security number

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 Certificatio*n forms submitted in the past.

Subscriber's signature

Date (mm/dd/yyyy)

4 To return this form

For first-time certifications

Employees: Return this form and any required documents to your payroll or benefits office (or upload in Benefits 24/7 at **benefits247.hca.wa.gov**).

Retirees, PEBB Continuation Coverage subscribers, and PEBB Continuation Coverage (Employer Group Ended Participation) subscribers: Return this form and any required documents to the PEBB Program (or upload in Benefits 24/7 at **benefits247.hca.wa.gov**).

For recertifications

Return your forms and any required documents to:
Mail: Health Care Authority
PEBB Program
PO Box 42684
Olympia, WA 98504-2684

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:** Contact your payroll or benefits office. **Retirees and PEBB Continuation Coverage subscribers:** Call the PEBB Program at 1-800-200-1004 (TRS: 711).

HCA's Privacy Notice: HCA will keep your information private except as allowed by law. To see our Privacy Notice, visit the HCA website at **hca.wa.gov/erb**.