Washington State Health Care Authority
Public Employees Benefits Board

Public Employees Benefits Board (PEBB)

Extended Dependent Certification

Guidelines for Extended Dependent Approval

An extended dependent is a child who is not your child through birth, adoption, marriage, or a qualified domestic partnership. Some examples of extended dependents include, but are not limited to, a grandchild, niece, or nephew for whom you, your spouse, or qualified domestic partner are the legal guardian or have legal custody.

The following are guidelines for determining if the child you want to enroll qualifies as an extended dependent. If these guidelines are met, the child may be eligible; however, the Health Care Authority (HCA) will determine eligibility using the information on this form and a copy of the legal document you submit with the form.

1. The child's official residence is with the guardian or custodian. A dependent's temporary domicile at school or other arrangement does not disrupt their official residence or custody of the guardian.
2. You must provide a court order signed by a judge or an officer of the court showing that you have legal custody, guardianship, or temporary guardianship.
3. The child must not be a foster child for whom support payments are made to you through the Department of Social and Health Services (DSHS) foster care program.

The child is *not eligible* for coverage as an extended dependent if the above requirements are not met.

If the child is age 20-24 and no longer qualifies as an extended dependent, he or she may qualify for PEBB coverage as an adult dependent. You can find the *Adult Dependent Enrollment/Change* form on our Web site at **www.pebb.hca.wa.gov**.

- **Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.**
- **Please make a copy of the completed form for your records.**
- **Attach a completed enrollment form along with this form if this is a new enrollment.**

Subscriber Information

Agency/Sub Agency

❑ New enrollment
❑ Recertification

Last name	First name	Middle initial	Social security number		
Mailing address			City	State	ZIP Code
Work phone number ( )			Home phone number ( )		

Dependent Child Information

Please complete additional certification forms if your dependent is disabled or a student.

I request to cover this child under: ❑ Medical ❑ Dental Life insurance: (attach a completed *Life Insurance Enrollment Form* if not currently enrolled) ❑ Part B Basic ❑ Part E with dependent

Relationship to subscriber	Last name	First name	Middle initial
Social security number	Date of birth (mm/dd/yyyy)	❑ Disabled? ❑ Student? (Check only if age 20 or older.)	

❑ Female
❑ Male

Does this child live with the subscriber?

❑ Yes When did the child begin living with subscriber? (mm/dd/yyyy) ____________________

❑ No With whom does the child live? Name: ____

Address: ____

(continued on back)

Subscriber's name	Social security number
Dependent child's name	

If the answer to any of the following questions is "Yes," the child does NOT qualify for coverage as an extended dependent.

Is anyone receiving payment under the Washington State Department of Social and Health Services foster care program for this child? ❑ Yes ❑ No

Is this child eligible for the DSHS foster care program? ❑ Yes ❑ No

Please explain the circumstances under which this child has been added to your household. ___________________________________

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This subscriber is responsible for notifying the HCA if there are any changes in the extended dependent's status throughout the year.

You must provide a copy of legal custody, guardianship, or temporary guardianship signed by a judge or an officer of the court for this child with this application.

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, I must repay any claims paid by my health plan or premiums paid on my dependent's behalf. My dependent may also lose PEBB benefits as of the last day of the month he or she qualified. 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 family members. I understand that the PEBB Program may ask for this verification at any time.

This form replaces all previous *Extended Dependent Certification* forms I have submitted for PEBB benefits.

HCA's Privacy Notice: We keep your information private as allowed by law. To see our Privacy Notice, call 360-923-2822 or go to **www.hca.wa.gov.**

Subscriber's signature____ Date ____________________________

Questions? Call the PEBB Program at 1-800-200-1004.

Mail completed form and documentation to:
Washington State Health Care Authority
PEBB Program
P.O. Box 42684
Olympia, WA 98504-2684
or fax to: **360-923-2608**