Washington State Health Care Authority
Public Employees Benefits Board

Clear Form

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 state-registered domestic partnership. Some examples of extended dependents include, but are not limited to, a grandchild, niece, or nephew for whom you, your spouse, or state-registered domestic partner are the legal guardian or have legal custody.
The following guidelines determine if the child you want to enroll qualifies as an extended dependent:

1. The child's official residence must be with the guardian or custodian;
2. You must provide a valid court order showing that you have legal custody, guardianship, or temporary guardianship; and
3. The child cannot be a foster child for whom support payments are being made 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 these guidelines are met, the child may be eligible; however, the Health Care Authority (HCA) will determine eligibility using the information you submit on this form and the legal documents you submit with this form.

Initial Certification. *First-time certification of an extended dependent.*

Employees	***Retirees, COBRA, Continuation Coverage, or Leave Without Pay (LWOP)***
Your completed *Employee Enrollment/Change* form AND Your completed *Extended Dependent Certification* form along with a copy of a valid court order showing legal custody or guardianship **must be received** by your personnel, payroll, or benefits office within the following timelines: • **New employees.** Within 31 days of becoming eligible for Public Employee Benefits Board (PEBB) benefits. • **Current employees**. No later than: ▪ The last day of the PEBB Program's annual open enrollment period, or ▪ 60 days after a qualifying special open enrollment event.	Your completed *Election/Change* form AND Your completed *Extended Dependent Certification* form along with a copy of a valid court order showing legal custody or guardianship **must be received** by the PEBB Program within the following timelines: • **New retirees.** Within 60 days after your employer-paid or COBRA coverage ends. • **New COBRA, PEBB Continuation Coverage, or LWOP subscribers.** Within 60 days of the mailing date of the *PEBB Continuation of Coverage Election Notice* sent to you. • **Current retirees, COBRA, PEBB Continuation Coverage, and LWOP subscribers.** No later than: ▪ The last day of the PEBB Program's annual open enrollment period, or ▪ 60 days after a qualifying special open enrollment event.

Recertification. *Review of an employee, retiree, COBRA, PEBB Continuation Coverage, or LWOP subscriber's currently certified dependent when requested by the PEBB Program.* This form **must be completed and received by the PEBB Program within the timeframe explained in the letter you received requesting the recertification.**

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Extended Dependent Certification *(continued)*

Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.

If the answer to the following question 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 (DSHS) foster care program for this child?	☐ Yes ☐ No

Subscriber Information	Agency/Sub agency		☐ New enrollment ☐ Recertification
Last name / First name / Middle initial			Social Security number
Address / Apt./unit number	City	State	ZIP Code
Mailing address (if different) / Apt./unit number	City	State	ZIP Code
Work phone number ( )	Home phone number ( )		

Dependent Child Information

I request to cover this child under: ☐ Medical ☐ Dental

To enroll this child in child life insurance, please visit **https://mybenefits.metlife.com/wapebb** or call 1-866-548-7319.

Relationship to subscriber	Last name / First name / Middle initial	
Child's Social Security number	Date of birth (mm/dd/yyyy)	☐ Female ☐ Male

Disabled? *Check only if age 26 or older.*

☐ **Yes** ☐ **No**

If yes, also complete the *Certification of Dependent With a Disability* form and submit to the address on the form.

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

☐ **Yes:**
When did the child begin living with subscriber? (mm/dd/yyyy) _____

☐ **No:**
Who does the child live with?

Name _____

Address _____

_____

(continued)

Extended Dependent Certification *(continued)*

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

If the child's status as your extended dependent changes at any time after you submit this form, you must notify your personnel, payroll, or benefits office if you are an employee. All others must notify the PEBB Program within the required timelines.

You must provide with this application a copy of valid court documents granting legal custody, guardianship, or temporary guardianship.

- **Please make a copy of the completed form for your records.**
- **If this is a new enrollment, attach this form to your completed *Enrollment Election/Change* form.**

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 Program rules, to the extent permitted by federal and state law, I must repay any claims paid by my health plan(s) or premiums paid on my dependent's behalf. My dependent may also lose PEBB Program benefits as of the last day of the month he or she qualified. To the extent permitted by law, the PEBB Program may retroactively cancel coverage for my dependent if I materially 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 Program benefits, and loss of my job.

The PEBB Program will verify eligibility for my family members. I understand that the PEBB Program may ask for this verification at any time.

This form replaces all *Extended Dependent Certification* forms previously submitted to the PEBB Program.

HCA's Privacy Notice: We keep your information private as allowed by law. To see our Privacy Notice, 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:

PEBB Program
Washington State Health Care Authority
PO Box 42684
Olympia, WA 98504-2684

or fax to: 360-725-0771