

Certification of Dependent With a Disability

After turning age 26, your dependent may be eligible for enrollment under your Public Employees Benefits Board (PEBB) Program health plan coverage if:

- Your dependent’s developmental disability or physical handicap occurred before age 26, and
- He or she is incapable of self-sustaining employment, and depends on you for support and ongoing care.

Initial Certification. <i>First-time certification of a currently enrolled dependent’s disability status after he or she turns age 26, or first-time certification of a newly enrolled dependent with a disability who is age 26 or older.</i>	
Employees Your completed <i>Employee Enrollment/Change</i> form must be received by your personnel, payroll, or benefits office, AND Your completed <i>Certification of Dependent With a Disability</i> form must also be received by the medical plan* you elected on your <i>Employee Enrollment/Change</i> form within the following timelines: <ul style="list-style-type: none"> • New employees. Within 31 days of becoming eligible for PEBB benefits. • Current employees. No later than: <ul style="list-style-type: none"> ▪ The last day of the PEBB Program’s annual open enrollment period, or ▪ 60 days after a qualifying special open enrollment event. *Medical plan contact information on the back of this form.	Retirees, COBRA, Continuation Coverage, or Leave Without Pay (LWOP) Your completed <i>Election/Change</i> form must be received by the PEBB Program, AND Your completed <i>Certification of Dependent With a Disability</i> form must also be received by the medical plan* you elected on your <i>Election/Change</i> form within the following timelines: <ul style="list-style-type: none"> • New retirees. Within 60 days after your employer-paid or COBRA coverage ends. • New COBRA or PEBB Continuation Coverage subscribers. Within 60 days of the mailing date of the <i>PEBB Continuation of Coverage Election Notice</i> sent to you. • Current retirees, COBRA, PEBB Continuation Coverage, and LWOP subscribers. No later than: <ul style="list-style-type: none"> ▪ The last day of the PEBB Program’s annual open enrollment period, or ▪ 60 days after a qualifying special open enrollment event. *Medical plan contact information on the back of this form.
Recertification. <i>Review of an employee, retiree, COBRA, PEBB Continuation Coverage, or LWOP subscriber’s currently certified dependent when requested by the medical plan or PEBB Program. This form must be completed and received by your medical plan within the timeframe explained in the letter you received requesting the recertification.</i>	

Instructions: Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage. Complete “Subscriber Information” and “Dependent Information” sections; your provider must complete the “Physician” section on the second page of this form.

Subscriber Information					
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 ()		Agency/Subagency	
Dependent Information					
Last name		First name		Middle Initial	Social Security number
This is a(n) (check one): <input type="checkbox"/> New enrollment <input type="checkbox"/> Recertification <input type="checkbox"/> Enrollment at or after age 26 <input type="checkbox"/> Special open enrollment		Is dependent enrolled in Medicare? (If yes, attach copy of Medicare card or entitlement letter.) Part A (hospital) <input type="checkbox"/> Yes <input type="checkbox"/> No Part B (medical) <input type="checkbox"/> Yes <input type="checkbox"/> No		Relationship to subscriber <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Legal extended dependent	
Has this dependent ever been employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list the employer name(s), address(es) and date(s) of employment:			Is this dependent currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list the employer name(s), address(es), date(s) of employment, and hours worked:		

Certification of Dependent With a Disability

Subscriber's last name	First name	Middle Initial	Social Security number
------------------------	------------	----------------	------------------------

Physician: Complete this section <i>The subscriber must pay any fees for completing this form.</i>			
Physician's last name		First name	
		MI	
Mailing address		City	State
		ZIP Code	
Is this child chiefly dependent on the subscriber for support and ongoing care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain why under "Nature of disability" below.			
Has disability existed continuously since before age 26? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what date did disability first exist?			
Nature of disability, including diagnosis (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 accurate.			
Physician's signature _____			Date _____

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, to the extent permitted by federal and state law, I must repay any claims paid by my health plan or premiums paid on my dependent's behalf. 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 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 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. However, the PEBB Program will verify the disability and dependency of adult dependents with a disability periodically, but not more frequently than annually after the two-year period following the dependent's 26th birthday. The PEBB Program may delegate verification of disability to the subscriber's health plan. This form replaces all previous *Certification of Dependent With a Disability* forms I have submitted for PEBB benefits.

HCA's Privacy Notice:

We will keep your information private as allowed by law.
To see our Privacy Notice go to www.hca.wa.gov/public-employee-benefits.

Subscriber's signature _____ Date _____

Subscriber: Mail completed form as described below.

<p>Group Health Cooperative enrollees complete and submit this form to:</p> <p>Group Health Cooperative Clinical Review Unit, AMB-2 12400 E. Marginal Way S Tukwila, WA 98168-9801</p> <p>Toll-free fax: 1-800-377-8853 Clinical Review Unit: 1-800-289-1363 (Select option 2, then option 4.)</p>	<p>Uniform Medical Plan enrollees complete and submit this form to:</p> <p>Regence BlueShield M/S BU231 333 Gilkey Road Burlington, WA 98233</p> <p>Toll-free fax: 1-855-639-3940 Customer Service: 1-888-849-3681</p>	<p>Kaiser Permanente or dental only enrollees complete and submit this form to:</p> <p>PEBB Program PO Box 42684 Olympia, WA 98504-2684</p> <p>Fax: 360-725-0771 Customer Service: 1-800-200-1004</p>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------