SEBB Extended Dependent Certification

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

A Guidelines for extended dependent approval

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

- The extended dependent is not be 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 (SDRP) have legal custody or guardianship.
- The extended dependent is not a foster child unless you or your spouse or SDRP 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.

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 SEBB Program.

Follow the instructions below to certify or recertify an extended dependent. The form begins on page 3.

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 SEBB election or change form.

Forms must be received within the timelines described below:

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

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

Newly elected school board members: No later than 60 days after term begins.

Currently enrolled subsribers: No later than the last day of the SEBB Program's annual open enrollment, or 60 days after a qualifying open enrollment event.

C Recertification instructions

If your extended dependent is enrolled and must recertify

The SEBB Program must receive this completed 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 valid court documents granting legal custody, guardianship, or temporary guardianship with this form.
- Make a copy of the forms for your records.

E 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 on the HCA website at **benefits247.hca.wa.gov**).

SEBB Continuation Coverage: Return this form and any required documents to the SEBB Program using one of the methods listed below (or upload in Benefits 24/7 on the HCA website at **benefits247.hca.wa.gov**).

For recertifications

Return your forms and any required documentation to:

Mail:

Health Care Authority
SEBB Program
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:** Contact your payroll or benefits office. **SEBB Continuation Coverage members:** Call the SEBB 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**.

SEBB Extended Dependent Certification

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

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

Country

Mailing address (if different)

Mailing address line 2

City

State

ZIP/Postal code

Country

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***.

SEBB Extended Dependent Certification

Subscriber's Last name

Social Security number

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 you answered **yes** to the first question, and **no** to the second question, the child does not qualify for coverage as an extended dependent.

What kind of certification is this?

New enrollment Recertification

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

Yes No

If **yes**, also complete the *SEBB 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 you (the subscriber)? (mm/dd/yyyy)

No. If **no,** who does the child live with?

Last name, first name

Street address

City

State

ZIP/Postal code

Country

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 law. My dependent may also lose SEBB health plan coverage 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. 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 SEBB benefits.

The SEBB Program will verify eligibility for my dependents. I understand that the SEBB Program may ask for this verification at any time and that I must submit recertification forms and documents so the SEBB Program receives them within the required timelines.

This form replaces all *SEBB Extended Dependent Certification* forms submitted in the past.

Subscriber's signature

Date (mm/dd/yyyy)