Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

2020 PEBB Certification of a Child With a Disability

After turning age 26, your child may be eligible for enrollment in your Public Employees Benefits Board (PEBB) health plan if:

- Your child's developmental or physical disability occurred before age 26.
- They are incapable of self-sustaining employment and chiefly dependent upon you for support and ongoing care.

Initial certification

First-time certification of:

- A currently enrolled child's disability status after they turn age 26.
- A newly enrolled child with a disability who is age 26 or older.

If your dependent is only enrolling in dental coverage, submit this certification form to the PEBB Program. The timelines listed below apply.

Employees

Send a *PEBB Employee Enrollment/Change* form to your employer. Send your certification form to the medical plan you chose on your enrollment/change form. Their address is on page 3.

The forms must be received as described below:

- **Newly eligible employees:** No later than 31 days after becoming eligible for PEBB benefits.
- **Currently eligible employees:** No later than the last day of the PEBB Program's annual open enrollment, or 60 days after a qualifying event that creates a special open enrollment. See **hca.wa.gov/erb** for a list of qualifying events.
- **Currently enrolled child turning age 26:** No later than 60 days after the disabled dependent turns age 26.

Retirees or PEBB Continuation Coverage subscribers

Send the appropriate PEBB election or change form to the PEBB Program. Send your certification form to the medical plan you chose on your election/change form. Their address is on page 3.

The forms must be received as described below:

- **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 you leave public office.
- **New continuation coverage subscribers:** No later than 60 days from the date PEBB health plan coverage ended or from the postmark date on the *PEBB Continuation Coverage Election Notice* sent to you, whichever is later.
- **Current retirees or continuation coverage subscribers:** No later than the last day of the PEBB Program's annual open enrollment, or 60 days after a qualifying event creates a special open enrollment. See **hca.wa.gov/erb** for a list of qualifying events.
- **Currently enrolled child turning age 26:** No later than 60 days after the disabled dependent turns age 26.

For more enrollment events, see PEBB Program Administrative Policy 36-1 at **hca.wa.gov/pebb-rules**.

Recertification

Review of a currently certified child when requested by the medical plan or PEBB Program. Your medical plan (or the PEBB Program if dental only) must receive this certification form **by the child's scheduled PEBB coverage termination date**. This date is listed in the letter we mailed you about the recertification.

Instructions: Type or print clearly in dark ink. Inaccurate, incomplete, or illegible information may delay coverage. Complete the "Subscriber Information" and "Child Information" sections. Your provider must complete the "Physician" section.

Subscriber Information

Last name | First name | Middle initial | Social Security number

Street address | Apt./unit | City | State | ZIP Code

Mailing address (if different) | Apt./unit | City | State | ZIP Code

Home phone number | Alternate phone number

Child Information

Last name | First name | Middle initial | Social Security number

This is a(n)

- New enrollment
- Enrollment at age 26
- Annual open enrollment
- Recertification
- Special open enrollment

Is the child enrolled in Medicare? (If yes, attach copy of the Medicare card or entitlement letter.)

Part A (hospital) Yes No

Part B (medical) Yes No

Relationship to subscriber

- Child
- Stepchild
- Extended dependent (validated by a court order)

Subscriber's last name | First name | Middle initial | Social Security number

Has this child ever been employed? Yes No
If yes, list all of the employer names, addresses, and dates of employment:

Is this child currently employed? Yes No
If yes, list all of the employer names, addresses, and dates of employment, and hours worked:

Physician: Complete this section

The subscriber must pay any fees for completing this form.

Physician's last name (please print) | First name | Middle initial

National Provider Identifier (NPI) number

Mailing address | Apt./unit | City | State | ZIP Code

Is this child chiefly dependent on the subscriber for support and ongoing care? Yes No
If yes, please explain why under "Nature of disability" below.

Has disability existed continuously since before age 26? Yes No

If no, what date did disability first exist? (dd/mm/yyy):

Nature and level of disability, including diagnosis with ICD Code (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 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 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 child'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 and applicable premium surcharges when due. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of benefits. The PEBB Program requires eligibility verification of all dependents. I understand that the PEBB Program may ask for this verification at any time. However, the PEBB Program will verify the disability and dependency for a child with a disability periodically, but not more often than annually after the two-year period following the dependent's 26th birthday. The subscriber's medical plan will provide input. However, the PEBB Program certifies the child's eligibility. This form replaces all previous *Certification of a Child With a Disability* forms I have submitted for PEBB benefits. I understand that I must notify the PEBB Program in writing within 60 days of the last day of the month my child is no longer eligible as a child with a disability.

HCA's Privacy Notice: We will keep your information private as allowed by law. to see our Privacy Notice, go to **hca.wa.gov/erb**.

Subscriber's signature _____ Date

Send this form to your medical plan (or the PEBB Program for dental only) at the address below.

Kaiser Foundation Health Plan of the Northwest

Attn: Employer and Broker Services, Membership Administration

500 NE Multnomah St.
Suite 100
Portland, OR 97232

Fax: 503-813-3109
Phone: 503-813-3613

Kaiser Foundation Health Plan of Washington

Clinical Review Unit

PO Box 34589
Seattle, WA 98124

Toll-free fax: 1-800-377-8853
Phone: 1-800-289-1363

Uniform Medical Plan

Regence BlueShield

M/S BU231
333 Gilkey Road
Burlington, WA 98233

Toll-free fax: 1-855-639-3940
Phone: 1-888-849-3681

PEBB Program

Health Care Authority

PO Box 42684
Olympia, WA 98504

Fax: 360-725-0771
Phone: 1-800-200-1004

HCA is committed to providing equal access to our services. If you need an accommodation, or require documents in another format, please call 1-800-200-1004 (TRS: 711).