

Public Employees Benefits Board (PEBB)

# Certification of Dependents With Disabilities

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

**Subscriber: Complete Subscriber and Dependent sections; you must have your doctor complete the Physician section on the back of this form.**

To qualify for PEBB coverage, a dependent age 20 or older with a disability must meet the following criteria:

1. The disability must occur before age 20 or during the time the dependent was eligible as a student.
2. If the child was enrolled in PEBB, evidence of the disability must be provided to PEBB within **60 days** of age 20 or losing eligibility as a student.
3. If the child was enrolled in PEBB as an eligible student (up to age 24) at the time the disability occurs, evidence of the disability must be provided to PEBB within **60 days** after student eligibility ends.
4. If the child was not enrolled in PEBB, evidence that the disability occurred before age 20 or when eligible as a student must be provided at the time of enrollment.
5. The dependent must be incapable of self-support due to the disability. (See WAC 182-12-260 for the definition of eligible dependents.)

Subscriber Information			
Last name	First name	Middle initial	Social Security Number
Address		City	State ZIP Code
Work phone number ( )		Home phone number ( )	

Dependent Information			
Last name	First name	Middle initial	Social Security Number
Date of birth	Age when disability occurred	Relationship to subscriber <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other	Was this student a registered student at the time of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has this dependent ever been employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this dependent currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is dependent enrolled in Medicare? If yes, attach copy of Medicare card. <input type="checkbox"/> Yes <input type="checkbox"/> No		Part A <input type="checkbox"/> Yes <input type="checkbox"/> No Part B <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is dependent enrolled in Medicare Part D? <input type="checkbox"/> Yes <input type="checkbox"/> No		Effective date _____	
List the employer names and addresses and dates of employment (use back of form if necessary)			

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 the PEBB rules, I must repay any claims paid by my health plan or premiums paid on my behalf. My family members and I may also lose PEBB benefits as of the last day of the month we 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 Benefits Services Program will verify eligibility for me and my family members.

This form replaces all previous forms and submissions I have made for PEBB benefits.

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

Subscriber's signature \_\_\_\_\_ Date \_\_\_\_\_

Agency/Sub Agency	<input type="checkbox"/> New <input type="checkbox"/> Recertification
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Subscriber's name \_\_\_\_\_ Social Security Number \_\_\_\_\_

<b>Physician: Complete this section</b> <i>(The subscriber must pay any fees for completing this form.)</i>			
Physician's last name	First name	Middle initial	
Mailing address	City	State	ZIP Code

Is this dependent capable of employment to independently support himself/herself?  Yes  No

If yes, please indicate  Full-time  Part-time If no, please explain why under "Nature of disability" below.

Has disability existed continuously since before age 20?  Yes  No If no, when 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 \_\_\_\_\_

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

**Mail completed form to:  
Washington State Health Care Authority  
PEBB Benefits Services Program  
P.O. Box 42684  
Olympia, WA 98504-2684**