

# 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 qualified domestic partnership. Some examples of extended dependents include, but are not limited to, a grandchild, niece, or nephew for whom you, your spouse, or qualified domestic partner are the legal guardian or have legal custody.

The following are guidelines for determining if the child you want to enroll qualifies as an extended dependent. If these guidelines are met, the child may be eligible; however, the actual determination will be made by the Health Care Authority (HCA) using the information on this form and a copy of the legal document you submit with the form.

1. The child's official residence is with the guardian or custodian. A dependent's temporary domicile at school or other arrangement does not disrupt their official residence with and custody of the guardian.
2. You must provide a court order signed by a judge or an officer of the court showing that you have legal custody, guardianship, or temporary guardianship.
3. The child must not be a foster child for whom support payments are made to you 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.**

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- Please make a copy of the completed form for your records.
- Attach a completed enrollment form if this is a new enrollment.

<b>Subscriber Information</b>		Agency/Sub Agency		<input type="checkbox"/> New	
				<input type="checkbox"/> Recertification	
Last name	First name	Middle initial	Social security number		
Mailing address			City	State	ZIP Code
Work phone number ( )			Home phone number ( )		

## Dependent Child Information Please complete additional certification forms if your dependent is disabled or a student.

I request to cover this child under:  Medical  Dental Life insurance: (attach a completed *Life Insurance Enrollment Form*)  
 Part B Basic  Part E with dependent

Relationship to subscriber	Last name	First name	Middle initial
Social security number	Date of birth (mm/dd/yyyy)	<input type="checkbox"/> Disabled? <input type="checkbox"/> Student? (Check only if age 20 or older.)	
<input type="checkbox"/> Female <input type="checkbox"/> Male	Does this child live with the subscriber? <input type="checkbox"/> Yes If yes, when did the child begin living with subscriber? (mm/dd/yyyy) _____ <input type="checkbox"/> No If no, with whom does the child live? _____		

**(continued on back)**

Subscriber's name	Social Security number
Dependent child's name	

**If the answer to any of the following questions 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

Is this child eligible for the DSHS foster care program?               Yes     No

Please explain the circumstances under which this child has been added to your household \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**This subscriber is responsible for notifying the HCA if there are any changes in the extended dependent status throughout the year.**

**A copy of legal custody, guardianship, or temporary guardianship signed by a judge or an officer of the court for this child MUST be provided with this application.**

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, I must repay any claims paid by my health plan or premiums paid on my dependent's behalf. My dependent may also lose PEBB benefits as of the last day of the month he or she 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. I understand that the PEBB Program may ask for this verification at any time.

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

HCA's Privacy Notice: We 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 \_\_\_\_\_

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

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