

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.
- Attach a completed enrollment form along with this form if this is a new enrollment.
- 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 child age 20 or older with a disability must be incapable of self-support due to a disability as defined in PEBB rules, which requires you to meet **one** of the criteria below:

- 1. If the child is not currently enrolled in PEBB coverage or is the dependent of a newly eligible subscriber**—You must provide evidence that the disability occurred before age 20 or when he or she qualified as a student under PEBB rules. You must do this within your enrollment timelines.
- 2. If the child is currently enrolled in PEBB coverage**—You must provide evidence of the disability within 60 days of the child turning age 20 or when he or she loses eligibility as a student under PEBB rules.

If the child is age 20 through 24 and no longer qualifies as a dependent with disabilities, he or she may qualify for PEBB coverage as an adult dependent. You can find the *Adult Dependent Enrollment/Change* form on our website at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov).

<b>Subscriber Information</b>			
Last name	First name	Middle initial	Social security number
Street address		City	State ZIP Code
Mailing address (if different from above)		City	State ZIP Code
Work phone number ( )	Home phone number ( )	Agency/Sub Agency	

<b>Dependent Information</b>			
Last name	First name	Middle initial	Social security number
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Recertification	Was this student a registered student at the time of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of birth (mm/dd/yyyy)	Age when disability occurred	Relationship to subscriber <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____	
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	
List the employer names and addresses and dates of employment (use back of form if necessary)			
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	

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 Program will verify eligibility for me and my family members.

This form replaces all previous *Certification of Dependents With Disabilities* 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, call 360-923-2822 or go to [www.hca.wa.gov](http://www.hca.wa.gov).

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

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 Program at 1-800-200-1004.**

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

**or fax to:  
360-923-2608**