

Student Certification/Change

To qualify for PEBB coverage, your student must be:

- Age 20 through 23.
- Attending high school or a registered student at an **accredited** secondary school, college, university, vocational school, or school of nursing.

Additional criteria are defined in Washington Administrative Code [WAC] 182-12-260 located at www.pebb.hca.wa.gov.

Instructions

- **The subscriber must complete, sign, and date this form.**
 - Newly eligible employees: Submit this form to your personnel, payroll, or benefits office no later than **31 days** after your date of eligibility.
 - Newly eligible retirees: Submit this form to PEBB no later than **60 days** after your active employment or COBRA coverage ends.
- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- If your student's status changes, you must complete and return a new *Student Certification/Change* form no later than **60 days** after the date of change.
- Report address changes to your personnel, payroll, or benefits office (employees) or the PEBB Program (all others).
- To terminate your student's coverage due to a qualifying event, complete Section 5, sign, and return the form to the PEBB Program no later than **60 days** after the event. If you don't, your student may lose his or her right to continuation of coverage. *(Examples of qualifying events include, but are not limited to, graduation, no longer attending school, obtained other health coverage, or student marries and is no longer an IRS dependent.)*

SECTION 1: Subscriber Information	
Name	Social security number
Street address	Home phone ()
Mailing address (if different than above)	Work phone ()
SECTION 2: Student Information	
Student name	Social security number
Street address (if different from subscriber)	Date of birth
Is this student married? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of marriage _____	
If yes, does this student qualify as your dependent under the Internal Revenue Code? <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION 3: Reason for Request <i>Check all that apply.</i>	
<input type="checkbox"/> I am a newly eligible employee or retiree. <input type="checkbox"/> I am recertifying a currently enrolled student or continuing enrollment for a student turning age 20. <input type="checkbox"/> Student lost other health coverage. <i>(You must provide proof of loss.)</i>	<input type="checkbox"/> He or she is a newly acquired student through the subscriber's marriage or Washington State-registered domestic partnership. <input type="checkbox"/> Other <i>(please explain)</i> _____ _____ _____
If none of the above apply, you may enroll your eligible student during PEBB's annual open enrollment.	

Section 4: Enrollment Information *Required*

Full name of school currently registered/attending	City	State	Registrar's phone ()
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Is your student currently attending school? Yes No

Please complete the entire chart below with previous and expected school attendance. If your child did not attend school for a quarter or semester, write *N/A* in the "Month/year started" space.

PREVIOUS SCHOOL ATTENDANCE for the 12 months before current enrollment	QUARTER	<input type="checkbox"/> Fall Month/year started _____	<input type="checkbox"/> Winter Month/year started _____	<input type="checkbox"/> Spring Month/year started _____	<input type="checkbox"/> Summer Month/year started _____
	SEMESTER	<input type="checkbox"/> Fall Month/year started _____	<input type="checkbox"/> Spring Month/year started _____	<input type="checkbox"/> Summer Month/year started _____	<input type="checkbox"/> Other Month/year started _____
EXPECTED SCHOOL ATTENDANCE for the 12 months after current enrollment	QUARTER	<input type="checkbox"/> Fall Month/year started _____	<input type="checkbox"/> Winter Month/year started _____	<input type="checkbox"/> Spring Month/year started _____	<input type="checkbox"/> Summer Month/year started _____
	SEMESTER	<input type="checkbox"/> Fall Month/year started _____	<input type="checkbox"/> Spring Month/year started _____	<input type="checkbox"/> Summer Month/year started _____	<input type="checkbox"/> Other Month/year started _____

Section 5: Termination of Student Coverage

Complete this section only if your student is no longer eligible for PEBB coverage, based on PEBB's eligibility rules (see WAC 182-12-260). You must notify us in writing no later than **60 days** after the date your student is no longer eligible (such as when he or she stops attending school). If you don't, your child may lose the right to continue coverage.

If your child no longer qualifies as a student and is age 20 through 24, 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.

If the student has graduated, he or she may qualify for PEBB coverage for three months after graduation. Graduation is defined as the successful completion of studies to earn a degree/certification, not the date of the graduation ceremony. If you do not want your student covered for the three-month period after graduation, you must notify us in writing.

- My student has graduated; his or her graduation date was _____ (month/day/year)
- My child no longer qualifies for PEBB student coverage, effective _____ (month/day/year)
- Last date of school enrollment _____ (month/day/year)

Section 6: Subscriber Certification and Signature *Required*

By signing this form, I attest 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 behalf. My student 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. The PEBB Program has the right to request completion of this form or copies of my student's transcripts to make decisions about eligibility or enrollment.

This form replaces all previous *Student Certification/Change* 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.

Subscriber's signature _____ Date _____

Newly eligible employees return form to:

Your personnel, payroll, or benefits office

All others mail completed form to:

Washington State Health Care Authority
PEBB Program
P.O. Box 42684
Olympia, WA 98504-2684

Or fax to: 360-923-2608