Washington State Department of CHILDREN, YOUTH & FAMILIES

Change Form Medical and Dental Benefits

Change Form Guidelines

You may submit this form to request a change to your medical or dental plan. You may also use this form to notify us of updates to your information or to notify DCYF that you wish to terminate your medical and dental insurance.

All items with an * are required. Your change will not be processed until DCYF receives a legible and complete form.

This coverage is for the family child care license holder only (in the case of co-owners, one licensee may apply for benefits), and is linked to their SSPS number. Benefits do not cover other family members such as spouses, dependents, or employees of the child care program.

If you have questions about this change form, voluntary termination of coverage or eligibility for health care benefits, email dcyf.healthcare@dcyf.wa.gov or you may call 1-866-201-8343. Additional information and resources are located on the child care health benefits program website.

MAIL TO:
Department of Children, Youth, and Families
Child Care Health Benefits Program
PO Box 40970
Olympia, WA 98504-0970

OR

EMAIL TO:
dcyf.healthcare@dcyf.wa.gov

*** CHANGE REASON- (Please check all that apply)**

☐ I wish to update my personal information ☐ I wish to update my provider preference
☐ I wish to terminate my health and dental insurance

PERSONAL INFORMATION - *All Fields are required

*FIRST NAME	*MIDDLE INITIAL	*LAST NAME

*SOCIAL SECURITY NUMBER (SSN) OR Individual Tax Identification Number (ITIN)	*SSPS NUMBER *(6-digits, found on your SSPS invoice include zeros)*	*DATE OF BIRTH *Month/Day/Year*
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*HOME ADDRESS MAILING ADDRESS (*if different*):	*CITY	*STATE	*ZIP

*PHONE NUMBER ( ) -	☐ MOBILE ☐ HOME ☐ WORK	*EMAIL ADDRESS (*DCYF will contact you using the email address you provide here*)

*GENDER ☐ MALE ☐ FEMALE ☐ PREFER NOT TO DISCLOSE

*MEDICAL CARE PROVIDER PREFERENCE ☐ AETNA ☐ KAISER PERMANENTE ☐ TERMINATE HEALTH AND DENTAL BENEFITS

*DENTAL CARE PROVIDER PREFERENCE ☐ DELTA ☐ WILLAMETTE

If you do not check a box, we will keep your last choice on file.

I am changing medical and/or dental benefits or updating my information as indicated on this change form. I understand if I choose to terminate health and dental benefits, this completed form must be received by the 15th of the current month for coverage terminated the last day of the current month. I understand that DCYF is responsible for determining eligibility for benefits and if at any time I do not meet eligibility requirements, my benefits will be terminated. By signing below, I attest that I am not eligible for other medical coverage, including Medicaid, and that the information in this application is true to the best of my knowledge. I further agree to a deduction of the required monthly health benefit co-share premium from my SSPS payment for these health benefits.

*Signature _____ *Print Name _____ *Date _____