Washington State Department of
CHILDREN, YOUTH & FAMILIES

Child Care Provider Change of Medical and Dental Benefits

Instructions

Use this form to:

- Change your medical or dental plan.
- Update your information.
- Cancel your medical and dental insurance.

How to complete the form:

- Fill in all items with *. These are required.
- Sign and date the form.
- Email or mail the completed form to DCYF.
    - Email to: dcyf.healthcare@dcyf.wa.gov
    - Mail to:
      Department of Children, Youth, and Families
      Child Care Health Benefits Program
      PO Box 40970
      Olympia, WA 98504-0970

Remember:

- DCYF can process the form if it is clear and complete. If the form is incomplete or hard to read, DCYF will ask you to resubmit the form.
- DCYF must receive the completed form by the 15th to make changes for the next month, or to end coverage on the last day of the current month.
- Coverage is for the family child care license holder only. If there are co-owners, one licensee may apply for benefits. It is linked to your SSPS number. Benefits do not cover spouses, dependents, or employees of the child care program.

Questions?

- Email dcyf.healthcare@dcyf.wa.gov
- Call 1-866-201-8343
- Learn more on the Child Care Health Benefits website:
  https://www.dcyf.wa.gov/services/early-learning-providers/childcarehealthbenefits

FORM

*Reason For Change - (Check all that apply)

☐ Update my personal information ☐ Update my provider preference

☐ End my health and dental insurance ☐ I have transferred my child care license

*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, including zeros)	*Date of Birth MM/DD/YYYY
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*Home Address _____ *City _____ *State __ *Zip _____

Mailing Address _____ City _____ State ___ Zip _____

*Phone Number _____ ☐ Mobile ☐ Home ☐ Work

*Email Address _____

(*DCYF will contact you at this email address)*

*Gender ☐ Male ☐ Female ☐ Prefer not to say

*Medical Care Provider Preference ☐ Aetna ☐ Kaiser Permanente

☐ Cancel health and dental benefits

*Dental Care Provider Preference ☐ Delta ☐ Willamette

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

By submitting this form, I understand:

- I am changing medical and/or dental benefits or updating my information.
- If I cancel health and dental benefits, DCYF must receive this completed form by the 15th of the month to end coverage on the last day of the same month.
- DCYF determines benefits eligibility.
- If at any time I do not meet eligibility requirements, DCYF will end my benefits.

By signing below, I attest that:

- The information in this application is true to the best of my knowledge.
- If I am continuing Child Care Health Benefits, I am not eligible for other medical coverage, including Medicaid, Medicare, Military, family coverage, or other employment-based coverage.
- I agree DCYF may deduct $30 from my SSPS payments for the monthly health benefit premium.

_____ _____ _____

*Signature *Print Name *Date