IMPORTANT INFORMATION ABOUT HEALTH COVERAGE FOR DEPENDENTS TO AGE 26

You are receiving this form because your dependent is eligible for continued coverage in 2010.

In March 2010, Congress enacted laws, including the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act of 2010, as well as amendments thereto (collectively, Health Care Reform Law) that impose significant new requirements on health plans.

The Health Care Reform Law requires group health plans that cover children to extend coverage to those children up to age 26

While the new law does not become effective until January 2011, the PEBTF is extending coverage for dependents who graduated from college after May 1, 2010, or who are turning age 19 or 23 between May 1, 2010 and December 31, 2010.

To continue coverage, your dependent:

- Must be under age 26 and enrolled on PEBTF coverage as of May 1, 2010
- Cannot be eligible for coverage (other than through a parent) under another eligible employer-sponsored health plan
- Can be married
- Does not have to live with member
- Does not have to be claimed on the parent's tax return
- Does not have to be a student

**To continue PEBTF coverage for your dependent, you must complete the information on the reverse side and return the completed form to the PEBTF within 30 days.
If you do not return the completed form within 30 days, your dependent will be terminated.**

**For your convenience, you may complete the Dependent Attestation online by visiting:
www.pebtf.org**

PEBTF

Pennsylvania Employees Benefit Trust Fund
150 South 43rd Street, Harrisburg, PA 17111-5700
717-561-4750 800-522-7279

DEPENDENT ATTESTATION FORM
(for Dependents to Age 26)

Note: All information requested below MUST be completed.

Active ☐ Retiree ☐ Retired State Police ☐

SUBSCRIBER INFORMATION (Please print or type):

1. Last 4 digits of your Social Security number: ___________
2. Name (First, M., Last): ___________
3. Address: Street ___________
   City ___________ State ___________ Zip Code ___________
4. Date of birth: ___________

The dependent must continue to be enrolled in the same plan in which the subscriber is enrolled.

To continue dependent coverage to age 26, this form must be completed and returned to the PEBTF within 30 days.

DEPENDENT INFORMATION (Please print or type):

5. Last 4 digits of dependent's Social Security number: ___________
6. Dependent's name (First, M., Last): ___________
7. Is Dependent's address the same as the subscriber? Yes ____ No ____
   (If address is not the same as the subscriber, please list address below)
8. Address: Street ___________
   City ___________ State ___________ Zip Code ___________
9. Telephone number: Home: ( ) ___________ Work: ( ) ___________
10. Dependent's date of birth: ___________

Please answer the following questions:

Is the dependent eligible for other employer-sponsored health coverage (other than through a parent)? Yes ____ No ____

Does the dependent have other employer-sponsored health coverage? Yes ____ No ____

If yes, what is the effective date of coverage? ___________

Provide name and address of dependent's employer

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SUBSCRIBER: I CERTIFY THAT THIS INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. BY SIGNING THIS CERTIFICATION, I AM AUTHORIZING THE PEBTF TO CONTINUE COVERAGE FOR MY DEPENDENT TO AGE 26.

Member's Signature: ___________ **Date Signed:** ___________

NOTE: Eligibility for benefit coverage for dependents to age 26 and continuation of this coverage is subject to periodic evaluation and recertification. Should dependent or any other information on this Attestation Form change at any time, benefit coverage may be reconsidered by the PEBTF.