Essential Pediatric Dental Coverage Attestation Form

For members of small groups (2-50 employees) only

In an effort to make health care more accessible, the Affordable Care Act (ACA) requires that all small group health plans provide coverage for a range of core services known as Essential Health Benefits (EHBs), one of which is pediatric dental care.

Enrollment

There are two ways in which CDPHP® is helping to ensure our members of small group health plans have this essential coverage:

1. Delta Dental Business Plans: If you enroll in a Delta Dental plan offered by your employer, we will also enroll you and your covered dependent(s) in a Delta Dental Pediatric Plan.

2. Delta Dental Pediatric Plan: If your employer is not offering (or you chose not to enroll in) a Delta Dental Business Plan through CDPHP, we will automatically enroll you and your covered dependent(s) in the Delta Dental Pediatric Plan.

Billing

Regardless of how you are enrolled in the Delta Dental Pediatric Plan through CDPHP, your employer is billed for all enrolled individuals (subscribers and dependents) who are 18 years of age or younger. Talk to your employer to find out if and how this cost is being shared with employees.

Attestation

If either you and/or any of your dependents are receiving the essential pediatric dental coverage from another plan not offered by CDPHP, you have the option to disenroll from the Delta Dental Pediatric Plan through CDPHP. If you have another dental plan but are unsure if it meets the essential pediatric dental coverage requirements, speak with your employer or the administrator of that plan. By signing below, you are attesting that you are already meeting the essential pediatric dental coverage requirements through another plan and are disenrolling from the CDPHP pediatric dental coverage through Delta Dental.

Subscriber Name: ______________________________ CDPHP ID #: ________________
Employer: ______________________________
Name of the company issuing the standalone dental coverage: ______________________________
Effective date of plan: ____________

Please list the applicable subscriber and/or dependents that have obtained standalone dental coverage.

Name	Relationship to Subscriber

SIGNATURE: AGREEMENT:

I certify that I, and/or any of the above-named dependent(s), have obtained standalone dental coverage that provides a pediatric dental essential health benefit through a NY State of Health™-certified standalone dental plan offered outside NY State of Health.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Signature______________________________ Date: ________________