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

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
DEPENDE NT AT TESTATION 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.

DEPENDE NT 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
   ________________________________________________________________
   ________________________________________________________________

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.