Essential Pediatric Dental Coverage Attestation Form

For members of small groups (1-100 employees) and individual plans only

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

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 *(if applicable)*:

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

Name	Effective Date of Change

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. This certification will be considered to be in effect throughout the period you are covered by CDPHP, unless you notify CDPHP that you no longer have pediatric dental coverage with another carrier.

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:**

Completed forms can be emailed to membership@cdphp.com, or faxed to (518) 641-4008.

Discrimination is Against the Law

Capital District Physicians' Health Plan, Inc., CDPHP Universal Benefits, Inc., and Capital District Physicians' Healthcare Network, Inc. (collectively referred to as CDPHP®) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.

Multi-language Interpreter Services

ATENCIÓN: Si habla otro idioma que no es el inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación de miembro (TTY: 711).

注意：如果您使用的語言不是英語，您可以免費獲得語言援助服務。請致電您會員ID卡上的電話（聽力障礙電傳：711）。