

# Dependent Certification Form - Patient Protection and Affordable Care Act

UPMC HEALTH PLAN

## A. Client and Employee Information

Group Name: \_\_\_\_\_

Group ID#: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Member ID#: \_\_\_\_\_

## B. Type of Activity (See important explanatory information below.) Check all that apply.

Date of Event:

\_\_\_\_/\_\_\_\_/\_\_\_\_

Change:

Add overage dependent from age 19 until age 26

Annual Enrollment

Remove overage dependent from age 19 until age 26

Certification for continuation of coverage

## Reason: Continuation of Coverage Pursuant to the Patient Protection and Affordable Care Act

Is the dependent currently covered by or eligible for any other employer-sponsored health plan (including coverage available to a dependent through a spouse's employer-sponsored health plan)?  Yes  No

If yes, is the dependent covered by or eligible for UPMC Health Plan coverage?  Yes  No

Please list the current UPMC Health Plan member ID, if applicable. \_\_\_\_\_

If not UPMC Health Plan, list insurance company name. \_\_\_\_\_

Is the dependent currently enrolled as a full-time student?  Yes  No

(Student status will not affect dependent's eligibility for continuation of coverage.)

## C. Overage Dependent Information

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Last First MI

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## D. Certification of Eligibility of Overage Dependent Under the Patient Protection and Affordable Care Act

An adult child may continue as a dependent on his or her parent's coverage from age 19 until age 26, provided that the adult child is not eligible to enroll in any other employer-sponsored health plan, including coverage available to a dependent through a spouse's employer-sponsored health plan.

### Signature attesting to the certification listed herein

I certify that the dependent above is under the age of 26 and is not eligible to enroll in any other employer-sponsored health plan, including coverage available to dependent through a spouse's employer-sponsored health plan and is eligible for coverage under the terms of this Certificate of Coverage. Such coverage is subject to periodic review by UPMC Health Plan. I further certify that this information is true and correct and is being provided for the purpose of securing insurance benefits for my dependent since he or she is over the age of 19. I further acknowledge that it is unlawful for any person to make a false or inaccurate statement for the purpose of acquiring insurance benefits and further acknowledge that any false or misleading statement herein may affect eligibility for benefits, to the extent otherwise permitted by law.

**Signatures of both employee and employee's dependent must be complete for this attestation to be valid for continuation of coverage.**

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 subjects such person to criminal and civil penalties.

Employee: \_\_\_\_\_  
Signature

Date: \_\_\_\_\_

Dependent: \_\_\_\_\_  
Signature

Date: \_\_\_\_\_

Client Representative: \_\_\_\_\_  
Signature

Title: \_\_\_\_\_