ADULT DEPENDENT COVERAGE CERTIFICATION FORM

Note: All information requested below MUST be completed.

Active ☐ Retiree ☐

SUBSCRIBER INFORMATION (Please print or type):

1. Social Security Number: _____
2. Name (First, M., Last): _____
3. Address: Street _____
   City _____ State _____ Zip Code _____
4. Telephone number: Home: ( ) _____ Work: ( ) _____

APPLYING FOR ADULT DEPENDENT COVERAGE:

The Adult Dependent must be enrolled in the same plan in which the subscriber is enrolled.

To apply for Adult Dependent Coverage, this form must be completed and returned to the PEBTF.

Note: Certification is required annually and the employee member must continue to make monthly payments in order for coverage to continue.

ADULT DEPENDENT INFORMATION (Please print or type):

5. 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: Month _____ Day _____ Year _____
11. Relationship to subscriber: ___ Natural/Adopted Child ___ Step-Child
    ___ Other _____
    (If other, please explain)
12. Please indicate effective date of coverage: _____
    (See reverse side for instructions)

Please answer the following questions:

Is adult dependent married? Yes ___ No ___

Does adult dependent have any dependents? Yes ___ No ___

Is adult dependent a resident of Pennsylvania? Yes ___ No ___

If yes, please indicate county of residence _____

Is adult dependent enrolled as a full-time student at an accredited educational institution? Yes ___ No ___

Please indicate name of educational institution _____

Is the adult dependent provided coverage under any other group or individual health insurance? Yes ___ No ___

Is the adult dependent able to be enrolled in or entitled to benefits under any government health care benefits program (i.e.. Medicare, Medicaid)? Yes ___ No ___

AUTHORIZATION FOR APPLICATION FOR ENROLLMENT: I hereby apply for enrollment in health care coverage. I understand this application will be submitted to, and is subject to approval by, the Pennsylvania Employees Benefit Trust Fund ("PEBTF") providing these and/or other health related benefits and will be subject to the terms of the PEBTF Plan. As condition precedent to payment of claims, and in consideration therefore, I also agree that the PEBTF shall have all legal rights of subrogation on my behalf and/or on behalf of my dependents for recovery against third parties and/or other providers legally obligated to pay such claims. Such subrogation rights shall be satisfied in full prior to the receipt by me or my dependent of any additional recovery or damages from third parties and/or other persons or entities legally obligated to pay such claims. I further agree that I will direct any attorney that I may retain to satisfy such subrogation interest in full and as a priority prior to the distribution of any recovery to me or my dependent. Any additional documents required for release of any such information or records, or for subrogation, will be promptly signed by me and/or my dependent. I further understand that, if at any time I fail to provide accurate information to the Plan or PEBTF, I will be required to repay any payments made as a result of such misinformation and I will be subject to being disqualified from receiving future benefits for such period of time as the PEBTF deems appropriate. I understand if I knowingly and with intent to defraud the Plan or the PEBTF, file an application for benefits which contains materially false information or conceals information containing a material fact for the purpose of misleading, such actions by me may be deemed to be fraudulent and subject me to criminal prosecution and civil penalties. Finally, I understand that the information contained in this application for enrollment may be used by the Commonwealth of Pennsylvania and the Plan or PEBTF for such administrative and actuarial purposes as they may deem appropriate.

Subscriber's Signature: _____ Date Signed: _____

Adult Dependent's Signature: _____ Date Signed: _____

NOTE: Eligibility for benefit coverage as an adult dependent and continuation of this coverage is subject to periodic evaluation and recertification and continuation of the payment of the monthly premiums. Should adult dependent or any other information on this certification form change at any time, benefit coverage may be reconsidered by the PEBTF.

IMPORTANT INSTRUCTIONS FOR ADULT DEPENDENT COVERAGE

Adult Dependent Coverage is offered to dependents up to age 30. Your dependent must meet the following criteria:

- Is not married
- Has no dependents
- Is a resident of Pennsylvania or is enrolled as a full-time student at an accredited educational institution of higher learning
- May not be provided coverage under any other group or health insurance
- May not be enrolled in or entitled to benefits under any government health care benefits program

The subscriber must be enrolled in both medical and supplemental benefits in order for the adult dependent to enroll in PEBTF coverage. The adult dependent must be enrolled in the same health benefit plan as the subscriber.

The effective date of coverage cannot be retroactive more than 60 days from the qualifying event. A qualifying event is due to age (age 19 or 26), or loss of employment.

You will not be officially enrolled until the initial payment is received by the PEBTF. Please contact the PEBTF for rate information.

Adult Dependent Coverage is a prepaid benefit; therefore, monthly invoices will be issued. In order to continue coverage, the PEBTF MUST receive your payment no later than the last day of the month prior to the coverage period. For example, for the coverage period beginning April 1st and ending April 30th, the PEBTF must receive payment by March 31st. If payment is not received by that date, the coverage will be canceled. Once coverage is canceled, it cannot be reinstated until the next open enrollment period or qualifying life event.

The subscriber must remain enrolled in PEBTF coverage. If the subscriber loses coverage under the PEBTF, Adult Dependent Coverage will be terminated as of the date the subscriber terminates.

PEBTF
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