33-10

OFFICE OF THE COUNTY EXECUTIVE
ALL-EMPLOYEES MEMORANDUM

DATE: October 22, 2010

COVERAGE OF ADULT CHILDREN UP TO AGE 26

In accordance with the Patient Protection and Affordable Care Act, effective January 1, 2011, coverage will be extended for adult child(ren) up to age 26 regardless of their financial dependency on the member, residency with the member, marital status, student status or employment status. An adult child is not eligible for coverage if he/she is eligible for health benefits coverage through his/her own employer-sponsored plan or his/her spouse's employer. When a child of an employee turns 26, their coverage will end the day prior to their birth date. (For example, child turns 26 on July 17, 2011, the last day the plan must cover the child is July 16, 2011.)

If your adult child(ren) "aged out" before age 26, you will have an opportunity to enroll your child(ren) during the period of November 1, 2010 through December 15, 2010, with an effective date of January 1, 2011.

To enroll your adult child(ren) who have not yet reached age 26, you must complete the attached "Health Benefits Transaction" form adding your adult child(ren) as well as the attached "Request for Coverage of Adult Child(ren) to Age 26" form. A separate "Request for Coverage of Adult Child(ren) to Age 26" form must be completed for each child.

Even if your adult child(ren) is/are currently eligible for benefits as your dependent because he/she is a full-time college student, you must resubmit completed "Health Benefits Transaction" and "Request for Coverage of Adult Child(ren) to Age 26" forms. Please note, you will no longer be required to complete the "Student Verification Form."

If you have any questions regarding enrollment for adult dependents to age 26, please contact the Employee Benefits Unit via e-mail at ebu@suffolkcountyny.gov or via telephone at 631-853-4866.

ED DUMAS
Chief Deputy County Executive

Distribution
One copy per employee

REQUEST FOR COVERAGE OF ADULT CHILD(REN) UP TO AGE 26

Submit Form to:
Employee Benefits Unit
P.O. Box 6100
Hauppauge, NY 11788

The Patient Protection and Affordable Care Act (PPACA) allows young adults, up to age 26, to continue his/her coverage through his/her parent's group health benefits through age 26. This option is available effective January 1, 2011. The young adult coverage is subject to all terms and conditions of the applicable health benefits plan. The adult child can only enroll under the plan in which his/her parent is currently enrolled.

Directions: To enroll your Adult Child(ren) (or for enrollment to continue for adult child(ren) who are currently full-time college students) who have not yet reached age 26, please complete this form and return it to the Employee Benefits Unit along with a completed Health Benefits Transaction Form to establish eligibility.

ADULT CHILD UP TO AGE 26 INFORMATION

Name and Mailing Address of Young Adult:	Social Security Number:
	Telephone Number (with area code)

PARENT ENROLLEE INFORMATION

Name and Mailing Address of covered parent:	Social Security Number:
	Telephone Number (with area code)

Parent enrolled under the following plan:

☐ EMHP ☐ HIP ☐ HIP/Vytra Premium ☐ Empire Direct

To qualify for coverage of an adult child up to age 26, you must be able to check "True" for all of the following statements:

1. My adult child is the natural or adopted child of a current Suffolk County enrollee or his/her spouse. ☐ True ☐ False
2. My adult child is **NOT** eligible for other group health plan coverage through either his/her employer sponsored plan or his/her spouse's employer sponsored plan. ☐ True ☐ False

EVIDENCE REQUIRED WHICH MUST BE SUBMITTED AT TIME OF ENROLLMENT

ADULT CHILD UP TO AGE 26 - Copy of Birth Certificate ☐ Yes ☐ No

EMPLOYER VERIFICATION - TO BE COMPLETED BY ADULT CHILD'S EMPLOYER AND IF MARRIED, TO BE COMPLETED BY THE ADULT CHILD'S SPOUSE'S EMPLOYER ALSO

I certify that I am authorized to make the following representations concerning the above named Adult Child and recognize that the County of Suffolk shall be entitled to rely on the truth of my statement below:

- He/she is not eligible for other group health plan coverage through his/her employer because his/her employer **does not offer** group health plan coverage to the above-named Adult Child; AND/OR
- He/she is not eligible for other group health plan coverage through his/her spouse's employer because his/her spouse's employer **does not offer** group health plan coverage to the above-named Adult Child.

Adult Child's Employer		**Adult Child's Spouse's Employer**	
Print Name:		**Print Name:**	
Signature:		**Signature:**	
Title:		**Title:**	
Company Name:		**Company Name:**	
Date:		**Date:**	
Phone:		**Phone:**	

YOUR COVERAGE WILL TERMINATE WHEN:

1. You voluntarily elect to terminate your coverage by sending notice to the Employee Benefits Unit;
2. Your parent is no longer enrolled in one of the County's health plans; or
3. You no longer meet the eligibility requirements for Coverage of Adult Children up to Age 26, e.g., you become eligible for other employer sponsored health benefits coverage or you reach age 26.

PLAN SELECTION

I am making an election for enrollment of my Adult Child up to age 26. To the best of my knowledge and belief, all of the answers provided on this form are true and correct. I have read and understand the rules regarding termination of coverage. **Specifically, I understand that if my adult child's employer, or my adult child's spouse's employer, offers group health plan coverage for my adult child, I must notify Suffolk County of this event and understand that coverage of my adult child under my health plan must be terminated.** I understand that any false or misleading statement made in order to receive benefits for which my Adult Child up to age 26 is not qualified will subject me to financial responsibility for any benefits paid and/or other legal actions appropriate to the prosecution of such fraud.

☐ I wish to enroll my Adult Child Up to Age 26.

If you have any questions, please contact the Employee Benefits Unit at 631-853-4866.

Parent Enrollee Signature: _____

Printed Name: _____

Date: _____

Sworn to Before Me
This _____ day of _____, 201____

_____
Notary Public

Please complete this form and return it to the Employee Benefit Unit at P.O. Box 6100, Hauppauge, NY 11788. Please provide the necessary documentation to establish eligibility.

FOR EMPLOYEE BENEFITS USE ONLY:

This application is: ☐ Approved ☐ Denied

If application is denied, reason for denial: _____

Signature of Employee Benefits Supervisor or Representative

Signature: _____ **Date:** _____

Print Name: _____ **Phone:** _____