Attestation of Pediatric Dental Coverage

The Affordable Care Act (ACA) requires dental coverage for anyone 18 or younger. This is called pediatric dental coverage. If you have a child 18 or younger covered by your Kaiser Foundation Health Plan of Washington medical plan, you will need to sign them up for pediatric dental coverage too.

We offer 2 dental plans issued and underwritten by Delta Dental of Washington (400 Fairview Ave N., Suite 800, Seattle, WA 98109-5371) that provide pediatric dental coverage. To sign up for one of these Delta Dental of Washington plans, please visit **kp.org/wa/dental** to download the Account Change Form, then complete and return it to us at the fax number or mailing address listed below within 60 days of the start date of your medical coverage. Instructions on where to send the Account Change Form are on page 5 of the form.

If you decide to sign up for pediatric dental coverage with another carrier, complete this Attestation of Pediatric Dental Coverage form and send it to us along with proof of dental coverage within 60 days of the start date of your medical coverage. Proof of dental coverage may include:

- A dental plan member ID card for each child covered and the dates of coverage
- A letter from the dental plan carrier that details each child covered and the dates of coverage

If you do not submit this information within the 60 days, you won't meet the minimum health and dental coverage that is required by Washington state and federal regulations.

If you have any questions about pediatric dental coverage or our dental plans, call Member Services at **1-800-290-8900 (TTY 711)**, Monday through Friday, 8 a.m. to 5 p.m.

Instructions

1. Complete sections A, B, and C of this form.

2. Print and sign the form.

3. Send the form and documentation via fax or mail.

Fax: 855-355-5334

Mail: Kaiser Foundation Health Plan of Washington
Membership Administration
P.O. Box 23127
San Diego, CA 92193-9921

Section A: Primary applicant's information

Primary applicant's name (last, first, middle initial, suffix)			
Date of birth	Gender: Female, Male		
Kaiser Permanente member record number	Phone number (mobile phone, if available)		
Home address (no P.O. boxes, please)	City	State	ZIP
Mailing address (if different from home address)	City	State	ZIP

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Section B: Dependent information

If you have more than 3 dependents to be covered, please fill out an extra copy of this page and submit with attestation.

Last name First name M. I.	Gender: Female, Male	Date of birth	KP member record #
Spouse/domestic partner			
Dependent			
Dependent			
Dependent			

Section C: Attestation and signature

☐ I do not want to enroll in dental coverage at this time. I certify that I have, or will have, other pediatric dental coverage for anyone 18 or younger covered by my medical plan within 60 days of my medical plan enrollment. I understand that pediatric dental coverage is a requirement under the Affordable Care Act and Washington state law and that if I don't obtain coverage, I won't meet the minimum necessary health and dental coverage that is required by Washington state and federal regulations.

Primary applicant's signature ______________________________ Date__________