



## HEALTH PLAN COMMUNITY

### INDIVIDUAL PEDIATRIC ESSENTIAL HEALTH BENEFIT ACKNOWLEDGEMENT

Applicant Name:

The undersigned Applicant understands that certain pediatric dental benefits are among the 10 categories of essential health benefits (EHBs) required under the Patient Protection and Affordable Care Act (PPACA). A failure to provide pediatric dental EHBs could result in the Applicant being non-compliant under PPACA. Applicant also understands that Qualified Health Plans (QHPs) purchased through McLaren Health Plan Community (MHP Community) do not include the pediatric dental EHBs needed to comply with PPACA requirements and that they must be purchased through Delta Dental or through another carrier.

Applicant certifies that he/she either purchased the required pediatric dental EHB through Delta Dental, or a separate qualified dental plan that covers the required pediatric dental care through another carrier.

Applicant Signature

Date:

Are you using an Agent? \_\_\_\_\_ Yes \_\_\_\_\_ No

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***If Applicant has an Agent, Agent must complete the additional attestation:***

As agent for the Applicant, in addition to the statement above, I also certify that this customer has purchased the pediatric dental essential health benefits needed to comply with PPACA requirements. I understand that failure to adhere to this certification can result in termination of my contract with MHP Community; nonpayment of commissions; or other penalties identified by MHP Community.

Agent Signature

Date:

Agent Name (Print)

Date: