BELLSOUTH

RF-2200
(11-92)
Front

Disabled Dependent Eligibility Request

Medical Plan

Conditions of Eligibility on Reverse Side of this Form

Dedicated Service Center
P.O. Box C-279
Birmingham, Alabama 35283-0279

Section I (To Be Completed By Employee/Retiree)

Name of Employee/Retiree	Address of Employee/Retiree	Social Security Number
Name of Dependent	Social Security Number of Dependent, If Any	
Dependent's Date of Birth (Mo./Day/Yr.)	Employee's Work Telephone Number ( )	

Was or is Dependent Hospitalized or Institutionalized? If Yes, Give Name and Address of Institution(s).

☐ No ☐ Yes

Period Confined
From ______
To ______

Is Dependent Eligible for Care Under Federal, State, or Local Law? If Yes, Give Details.

☐ No ☐ Yes

Was or is Dependent Employed for Wages? If Yes, Give Name and Address of Current or Last Employer.

☐ No ☐ Yes

Average Weekly Earning
$

If Was Employed, Give Reason for Termination.

Signature of Parent	Date Signed

Section II (To Be Completed By Physician. *Address and Telephone Number is Necessary)*

1. If the patient has been admitted, forward the form to the admitting officer of the hospital so that it may accompany the hospital's notice of admission.
2. If the patient is not admitted and the claim is for your services only, attach this statement to the Medical Claim Form.
3. If this form is solely for the purpose of determining eligibility in the event of future treatment, return to the employee.

Is Dependent Presently Incapable of Self-Sustaining Employment by Reason of ☐ Mental Disability ☐ Physical Disability	Is Incapacity Congenital? ☐ No ☐ Yes

Diagnosis of Condition Causing Disabled Status:

In Your Opinion, Will this Dependent Ever be Capable of Self-Sustaining Employment? ☐ No ☐ Yes

If Admitted as In-Patient, Give Name of Hospital.		Date Admitted
Address		Telephone No. ( )
Name of Attending M.D.	Signature of Attending M.D.	Date Signed

See Section III on Reverse Side

For Plan Office Use Only

Hold		Approved		Rejected	
By	Date	By	Date	By	Date

Attach additional sheets if necessary.

Section III (To Be Completed By Other Consultants)

1. List names, addresses, and phone numbers of any therapists (physical, occupational, speech, etc.) and include detailed evaluations by each.

2. Does dependent require the use of adaptive equipment? *Describe.*

3. List names, addresses, and phone numbers of any psychologists and/or psychiatrists who have rendered care to dependent and include detailed evaluation.

Conditions of Eligibility

Coverage for a Mentally or Permanently Physically Disabled Dependent Age 19 or Over

Under the provisions of your contract, a mentally or permanently physically disabled dependent will be considered for coverage regardless of age provided the dependent

- is not married
- is so incapacitated as to be incapable of self-sustaining employment
- is chiefly dependent upon the employee or retiree for support and maintenance
- is certified prior to age 19

Neither a reduction in work capability or inability to find employment are, of themselves, evidence of eligibility. If a mentally or permanently physically disabled dependent is working, despite his disability, the extent of his earning capability will be evaluated.

Important Point

A mentally or physically disabled dependent is eligible for all benefits of the contract.