

## Disabled Dependent Eligibility Recertification

**Medical Plan**

*Conditions of Eligibility on Reverse Side of this Form*

**Section I (To Be Completed By Employee/Retiree)**

Name of Employee/Retiree		Address of Employee/Retiree		Contract Number	
Name of Dependent			Social Security Number of Dependent, If Any		
Dependent's Date of Birth (Mo./Day/Yr.)		Employee's Work Telephone Number ( )		Employee's Home Telephone Number ( )	
Was or is Dependent Hospitalized or Institutionalized? If Yes, Give Name and Address of Institution(s) <input type="checkbox"/> No <input type="checkbox"/> Yes				Period Confined From _____ To _____	
Is Dependent Eligible for Care Under Federal, State, or Local Law? If Yes, Give Details. <input type="checkbox"/> No <input type="checkbox"/> Yes					
Was or is Dependent Employed for Wages? If Yes, Give Name and Address of Current or Last Employer. <input type="checkbox"/> No <input type="checkbox"/> Yes				Average Weekly Earning \$	
If Was Employed, Give Reason for Termination.				Is Dependent Married? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Is Dependent a Full-Time Student? <input type="checkbox"/> No <input type="checkbox"/> Yes		List Name and Address of School			
Is Dependent Covered by Other Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes		List Name and Address of Company			Is Dependent Covered by Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes
Provide Other Sources of Income and Amounts					

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

Is Dependent Presently Incapable of Self-Sustaining Employment by Reason of <input type="checkbox"/> Mental Disability <input type="checkbox"/> Physical Disability		Is Incapacity Congenital? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Diagnosis of Condition Causing Disabled Status:			

In Your Opinion, Will this Dependent Ever be Capable of Self-Sustaining Employment?  No  Yes  
Detailed Evaluation of Physical and/or Mental Condition. Please provide to date information and enclosed additional pages if necessary.

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.

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**Section III (To Be Completed By Other Consultants)**

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

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

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

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**Conditions of Eligibility**

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

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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.