

# Statement of Dependent Eligibility Beyond Limiting Age In Plan Due to Mental or Physical Disability



FAX: 844-236-0933  
E-mail: Disabled\_dep\_@uhc.com

**\*\*Questions should be directed to the Customer Service number located on the back of your ID card\*\***

**(E-mail for application submissions ONLY)**

## Employee's Statement

Employee to complete Sections I, II, & III. Omitted information will cause delays.

### Section I. Employee Information

PRINT Name: (First, Middle, Last)				Gender (Circle One) Male      Female	
Date of Birth / /	Social Security Number / /	Relationship to Dependent:	Marital Status: (Circle One) Single      Married Divorced      Widowed	Phone: (Including Area Code) ( )	
Current Address(es) (Street, City, State, Zip Code)					
Physical:					
Mailing:					
Email:					

### Section II. Dependent Information

(Refer to your Member Handbook for who qualifies as an eligible dependent.)

PRINT Name: (First, Middle, Last)				Gender (Circle One) Male      Female	
Date of Birth / /	Marital Status: (Circle One) Single      Married	Circle <b>all applicable</b> orders in place by Employee regarding Dependent. If circled, submit a copy of each with application.			
		Conservatorship	Guardianship	Court Order	Divorce Decree
Currently Resides at: (Street, City, State, Zip Code)					
Physical:					
Mailing:					
Does the Dependent reside in your household? (Circle one) <b>YES / NO</b>					
If <b>NO</b> , provide reason for different residing address than employee below. (Example: Lives in a group home, medical facility, etc.)					

### Section III. Financial and Dependent Employment Information

1. For New Employees, was dependent covered under your prior Employer's Insurance Plan? (Circle One) <b>YES / NO / Not Applicable</b>	
1a. If YES, provide coverage dates. From: ____/____/____ To: ____/____/____	
1b. If NO, please explain.	
2. Does employee provide more than 50% of the dependent's support and maintenance (food, meds, utility, housing, etc.)? (Circle One) <b>YES / NO</b>	
3. Was dependent listed as a dependent on your last Federal Personal Income Tax Return? (Circle One) <b>YES / NO</b>	
3a. If above is NO, provide explanation below.	
4. Does dependent receive SSDI/SSI benefits? (Circle one) <b>YES / NO</b>	4a. If YES, Amount per Month \$ _____ (Submit current copy)
5. Is dependent currently working? (Circle One) Full Time    Part Time    Currently Not Working    Date Last Employed _____	
5a. If dependent is currently working, Gross Monthly Income (before taxes) \$ _____	
5b. Does dependent's current employer offer health insurance? (Circle One) <b>YES / NO</b>	
5c. Provide Name and address of dependent's current employer below: (Street, City, State, Zip Code)	
6. Explanations/Additional Information: (attach additional pages if needed)	

I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH INFORMATION I KNOW IS FALSE OR TO LEAVE OUT INFORMATION I KNOW IS IMPORTANT.

Employee Signature:

Date: / /

For processing purposes, pages 1 and 2 MUST be submitted together.

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## Medical Provider Statement

(Any fee for the completion of this statement is to be paid by the employee.)  
Answer all questions below. Omitted information will cause delays.

Patient's Name: (First, Middle, Last)

Patient's Date of Birth

/ /

1. What is the primary disabling diagnosis?

2. From what Age has such disability existed continuously? (Circle One) From Birth From \_\_\_\_\_ Years of Age

3. The patient is presently: (Circle all applicable) Ambulatory Confined To: Bed House Hospital Wheelchair

4. What are the physical/mental/functional limitations related to the primary disabling diagnosis?

5. Are there any other diagnoses currently being treated? (Circle One) YES / NO

5a. If YES, please list:

6. Is patient currently able to work? (Circle One) YES / NO

6a. If YES, (Circle One) Full Time Part Time

7. Is patient currently able to be self-supportive? (Circle One) YES / NO

8. If you answered NO to either Question 6 or 7 above. Please explain below.

(circle all applicable) Intellectual/Developmental Disability Physical Handicap Mental Handicap Other (Explain below)

9. Will patient be capable of self-support in the future? (Circle One) YES / NO

9a. If YES, As of What Date: / /

**May attach any current (within the last three (3) months) written documentation or medical records.**

PRINT Medical Provider Name, Address (Street, City, State, Zip Code)

Phone: (Including Area Code)

( )

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▶ Medical Provider Signature:

Date: / /

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