

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



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

## Employee's Statement

Answer all questions below. Omitted information will cause delays.

Name (Print)	First	Middle	Last	Social Security Number / /	Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female
Present Address:	Street	City	State	Zip Code	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Phone (Including Area Code) ( )
Email Address:						

## Dependent Information

Name (Print)	First	Middle	Last	Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Present Address:	Street	City	State	Zip Code	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Relationship to Employee
Does employee provide more than 50% of the dependent's support? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Was dependent listed as a dependent on your last Federal Personal Income Tax Return? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Explain:						
Does employee have the following in place?		Conservatorship/Guardianship <input type="checkbox"/> Yes <input type="checkbox"/> No		Court Order/Divorce Decree <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does dependent receive SSDI/SSI benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, Amount per Month \$ _____		Estimated income of dependent from all sources \$ _____ monthly.
Is dependent currently employed? <input type="checkbox"/> Yes, <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> No, Date last employed ___/___/___						
Name and address of dependent's current employer:						
Explanations						

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: \_\_\_/\_\_\_/\_\_\_

## Physician's/Surgeon's 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 / /	Date or Age at "ONSET" of the disability: Age: _____ or Date: ___/___/___
The patient is presently: (Circle all applicable) Ambulatory    Bed Confined    House Confined    Hospital Confined    Wheelchair Confined					
Is patient presently "incapable" of self-sustaining employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date ___/___/___					
If yes, by reason of: (Circle all applicable) Intellectual/Developmental Disability    Physical Handicap    Mental Handicap    Other (Explain below)					
Please provide the <b>diagnosis</b> of the condition(s) causing the incapacitation and provide supportive documentation of the physical and/or functional <b>limitations</b> that prevent the dependent from being capable of self support. May attach any written documentation or medical records. <b>(Medical records/information provided "MUST" be dated within the last 3 months of completing this form)</b>					

Is patient able to do full or part time work?  Yes  No If yes, from \_\_\_/\_\_\_/\_\_\_

Will patient be capable of self support in the future?  Yes  No If yes, from \_\_\_/\_\_\_/\_\_\_

Physician's/Surgeon's Name (Print)	Address	Phone (Including Area Code) ( )
------------------------------------	---------	------------------------------------

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.

▶ Physician/Surgeon Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_