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

UnitedHealthcare®

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 **all applicable** 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) **YES / NO**

If **NO**, 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) **YES / NO / Not Applicable**

**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) **YES / NO**

**3. Was dependent listed as a dependent on your last Federal Personal Income Tax Return?** (Circle One) **YES / NO**

**3a. If above is NO, provide explanation below.**

**4. Does dependent receive SSDI/SSI benefits?** (Circle one) **YES / NO** | **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) **YES / NO**

**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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