APPLICATION FOR ELIGIBILITY AS A DISABLED DEPENDENT CHILD 19 YEARS OF AGE OR OLDER

Submit Form to:
Suffolk County Employee Benefits Unit
P.O. Box 6100
Hauppauge, NY 11788

BY COMPLETING THIS FORM THE ENROLLEE IS REQUESTING ELIGIBILITY BEYOND THE AGE ELIGIBILITY WOULD OTHERWISE TERMINATE, FOR A DEPENDENT CHILD WHO IS INCAPABLE OF SELF-SUSTAINING EMPLOYMENT DUE TO A DISABILITY. Please note that coverage for your dependent will not continue unless we receive, review and approve your paperwork at least 90 days before your dependent reaches age 26.

Section I (To Be Completed by Enrollee) *Please Print or Type*

Enrollee's Name | Social Security Number *(Last 4 digits)* XXX-XX-

Home Address (No. and Street) Apt# | City | State | Zip Code

Dependent Child's Name | Dependent Child's Date of Birth | Child's Sex __Male __ Female

Dependent Child's Relationship to Enrollee
[ ] Son [ ] Daughter [ ] Other_____

Dependent Child's Marital Status
[ ] Single [ ] Widowed [ ] Married [ ] Divorced

Dependent Child's Address: _____
City | State | Zip Code

The Dependent Child listed above is my unmarried child, stepchild or adoptive child and will or has reached the age of 19 or older. [ ] YES [ ] NO

The Dependent Child listed above permanently resides with me. [ ] YES [ ] NO

Has the Dependent Child listed above ever been institutionalized? [ ] YES [ ] NO
If Yes, give name and full address of institution _____
_____
Period of Confinement (dates)

Is Dependent Child a Full-time Student: [ ] YES [ ] NO
School Attending:_____
Is he/she currently on Medical Leave from School [ ] YES [ ] NO

Was the Dependent Child ever employed for wages: [ ] YES [ ] NO
Presently working at: _____ Date last worked: _____

Is the Dependent Child receiving government benefits related to this disability (Social Security, Worker's Compensation, Medicare, etc.)? [ ] YES [ ] NO
If "Yes", how much and at what frequency? _____
Effective Date of Medicare Eligibility: Part A _____ Part B _____

If the Dependent Child been found eligible for Supplemental Security Income (SSI) or Social Security disability insurance (SSDI), <u>you must</u> provide documentation of same (Example: Notice of award letter) [ ] YES [ ] NO

Is this a work-related illness, accident or disability? [ ] YES [ ] NO

If "Yes", have you applied for Worker's Compensation: [ ] YES [ ] NO

Is the disability related to an automobile accident? [ ] YES [ ] NO

IMPORTANT: This form will not be processed unless the physician's portion is completed in detail. Failure to submit the requested information may result in a delay, denial or termination of coverage for the above-named dependent.

I certify that I have carefully and fully read the important information on the preceding page of this form. I also certify that the statements and answers given are complete and correct to the best of my knowledge and belief. No information required to be given, either expressly or by implication has been knowingly withheld. I have provided supportive documentation on my dependent's disability as requested above and I am aware that without proper documentation coverage may be denied. I am also aware that additional information may be required to make a determination of coverage and that presenting this documentation does not imply automatic coverage.

I agree to promptly advise Suffolk County Employee Benefits Unit (EBU) within 30 days of any change that affects my disabled dependent's eligibility, including change of address, securing full-time, self-sustaining employment or elimination of the previously existing disability. I understand that any person who knowingly and with intent to defraud Suffolk County, any insurance company or any person who files an application for insurance/health benefits or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which may be a crime, and shall also be subject to a monetary responsibility for any claims paid on behalf of the otherwise ineligible individual.

I have attached a copy of my tax return indicating this child as my dependent.

Enrollee's Signature _____ Date_____

Your completed paperwork is required at least **90 days prior to** your dependent reaching his/her 26th birthday in order to avoid a lapse in coverage.

FOR NEW ENROLLMENTS ONLY: The enrollee must provide evidence that the dependent has had continuous health plan coverage, group or individual, prior to attaining the age at which eligibility for coverage terminates and the coverage remains in effect. You must attach a certificate of creditable coverage or evidence of prior coverage with this request.

Enrollee's Name: _____ **Dependent Child's Name:** _____

SECTION II – TO BE COMPLETED BY PHYSICIAN – Please answer all questions in detail. PRINT CLEARLY.

Is dependent child presently incapable of self-sustaining employment by reason of:

☐ Mental Illness ☐ Intellectual Disability What date did the incapacity begin: _____

☐ Physical Disability ☐ Developmentally Disabled Was condition the result of an accident ☐ YES ☐ NO

If yes, date of accident _____

Specific Nature of the Condition (including date such condition commenced)/Diagnosis:

Clinical findings/severity of illness and prognosis:

Functional Status/Prognosis for Independence (employment, residency, etc.):

Current Treatment (Date of Recent Evaluation (must be within six months of date this form is signed and submitted to the EBU) :

You must attach supporting documentation and/or additional pages to substantiate the above statements.

In your opinion, could this Dependent Child become capable of self-sustaining employment?

☐ YES ☐ NO ☐ NOT AT THIS TIME

Signature of Attending Physician	Specialty	Address & Phone Number	Date Signed

SECTION III – TO BE COMPLETED BY SUFFOLK COUNTY EMPLOYEE BENEFITS UNIT

I have reviewed the documentation submitted and verify that the dependent meets eligibility requirements of the Plan and accept the recommendation of the consultant as follows:

[ ] Permanently approved [ ] Temporarily approved through ____/____/____

[ ] Denied _____ _____

Employee Benefits Representative Signature Date