

Certification of Disabled Dependent Eligibility

IU-Sponsored Healthcare Coverage

This is a(n): Initial Certification Recertification

Employee Information:

Employee Name (Last, First, MI): _____ 10-digit ID: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (Work) _____-_____-_____ (Home) _____-_____-_____ E-mail: _____

Current IU-Sponsored Healthcare Plan(s): PPO \$900 Deductible PPO Blue Access HDHP PPO & HSA
 IUHQP Exclusive Provider IU Dental Plan

Disabled Dependent Child Information:

Dependent Name (Last, First, MI): _____ Date of Birth: ____/____/____

1.) Relationship to Employee: Biological or Adopted Child Stepchild Unlimited Guardianship

2.) Is this dependent child: Single Married Divorced

3.) Is this dependent child employed: Full-time Part-time (____ hours per week) Not employed

4.) Income Tax Status:

Was this dependent claimed as a dependent on the employee or employee's spouse's Federal Income Tax filing for 2010? Yes No

If no, would the dependent qualify to be claimed? Yes No Explain: _____

Will this dependent be claimed as a dependent on the employee's or employee's spouse's 2011 Federal Income Tax filing? Yes No

Has anyone else claimed this dependent for Federal Income Tax purposes? Yes No If Yes, Explain: _____

5.) Is this dependent legally residing in the employee's household? Yes No

If no, where is this dependent residing? _____

6.) Is this dependent presently insured by: Medicare Medicaid Other Medical Plan No Other Plan

If yes, list Health Plan and ID#: _____

7.) Does this dependent have personal resources (settlement, trust funds, etc.) that may provide financial support? Yes No

If yes, please explain: _____

Reverse side of this form must be completed and signed by the dependent's physician.

Physician Statement: (To be completed by the dependent child’s physician)

Employee Name: _____ Dependent Name: _____

The diagnosis of the disabled dependent is: _____

The dependent’s disability has been continuous since: ____/____/____
Mo. Day Year

Indicate the dependent’s prognosis for recovery in terms of months or years: _____

Describe the dependent’s symptoms that prevent him or her from engaging in self-sustaining employment in detail (i.e. extent of learning disability, etc.): _____

Is the dependent named now incapable of self-sustaining employment because of a physical or mental disability? Yes No

Name of Physician (print or type): _____

Physician’s Signature: _____ Date: ____/____/____

Eligibility for Disabled Dependent Coverage

Dependent children that are eligible for Disabled Child Coverage under an IU-sponsored health plan are those children who are:

- Fully disabled, that is, incapable of engaging in self-sustaining employment because of a mental or physical disability;
- Dependent on the employee for financial support and maintenance;
- Unmarried;
- Covered under the employee’s IU-sponsored health plan at the time the maximum age for covered dependents is reached.

Employee Certification:

I certify that the information I have provided in this application for my disabled dependent child is true and complete. I understand that any false information or statements will be grounds for Indiana University to void my health plan coverage and/or terminate my employment.

I certify that this disabled dependent meets IU’s Eligibility for Disabled Child Coverage, that is, the child is:

- Fully disabled, and is incapable of engaging in self-sustaining employment because of a mental or physical disability;
- Dependent on me for financial support and maintenance;
- Unmarried; and
- Does not have personal resources sufficient to be self-supporting (for example, trust funds or settlements).

Employee Signature: _____ Date: ____/____/____

This form, along with any supporting documentation, certifying that the child is fully disabled must be submitted to Indiana University Human Resource Services for review no later than 30 days prior to the date that coverage as a dependent would have ceased. Proof that the child remains fully disabled and is dependent on the employee for financial support may be required at reasonable intervals.

Return this completed form to: Deborah Lankford, University Human Resource Services, Poplars E165, 400 E. 7th Street, Bloomington, IN 47405-3085 or fax both sides to (812) 856-5677.