

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

Employee Name: _____ Dependent's 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 the dependent from engaging in self-sustaining employment in detail (i.e., extent of learning disability, etc.):

Is the dependent named in this application now incapable of self-sustaining employment because of a physical or mental disability? yes no

Name of Physician: (print or type name): _____

Physician's Signature: _____ Date: _____ / _____ / _____
Mo Day Year

Eligibility for Disabled Child 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
- 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, Indiana University Human Resource Services, Poplars Building E165, 400 East Seventh Street, Bloomington, IN 47405-3085, or fax both sides to 812-856-5677.