

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

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"/> Widowed <input type="checkbox"/> Divorced	Phone (Including Area Code) ()	

Dependent Information									
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		Relationship to Employee		
Name and address of dependent's current employer									
If not now employed, give date last employed		Estimated income of dependent from all sources \$ _____ monthly		Percentage of support of dependent supplied by employee _____ %		Is dependent permanently residing in employee's household? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Explain			
Is dependent listed as a dependent in your last Federal Personal Income Tax Return?						<input type="checkbox"/> Yes <input type="checkbox"/> No If No, Explain			
Explanations									
I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT. Signed (Employee)								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				
Is this dependent presently incapable of self-sustaining employment by reason of: Mental Retardation? <input type="checkbox"/> Yes <input type="checkbox"/> No Physical Handicap? <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Handicap? <input type="checkbox"/> Yes <input type="checkbox"/> No Other (explain) <input type="checkbox"/> Yes <input type="checkbox"/> No					Date dependent became incapable of self-sustaining employment.				
Diagnosis of condition causing incapacity. If mental retardation is present, give degree of retardation. Give as much detail as possible. Please give date and report of surgery, X-rays, electrocardiograms, or other special tests. Use a separate sheet of paper if necessary.									
Does the patient have a job? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Do you know what the patient's job is? <input type="checkbox"/> Yes <input type="checkbox"/> No				Do you know what duties the patient's job requires? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has this patient been able to do full or part-time work of any kind? <input type="checkbox"/> No <input type="checkbox"/> Yes, From _____ Date				Will the patient be capable of self support? <input type="checkbox"/> No <input type="checkbox"/> Yes, From _____ Date					
The patient is presently (check one) <input type="checkbox"/> Ambulatory <input type="checkbox"/> Bed confined <input type="checkbox"/> House confined <input type="checkbox"/> Hospital confined									
Physician's/Surgeon's Name (Print)					Address			Phone (Including Area Code) ()	
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For Use By United HealthCare

Dependent eligibility will continue to			Month	Day	Year
Dependent eligibility declined. Give reason.					
Signature					Date