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

UnitedHealthcare®

FAX : 844-236-0933
Disabled_dep_@uhc.com

Employee's Statement

Answer all questions below. Omitted information will cause delays.

Name (Print) First Middle Last | Social Security Number / / | Date of Birth / / | ____ Male ____ Female

Present Address: Street City State Zip Code | Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed | Phone (Including Area Code) ( )

Email Address:

Dependent Information

Name (Print) First Middle Last | Date of Birth / / | ____ Male ____ Female

Present Address: Street City State Zip Code | Marital Status: ____ Single ____ Married | Relationship to Employee

Does employee provide more than 50% of the dependent's support? ____ Yes ____ No

Was dependent listed as a dependent on your last Federal Personal Income Tax Return? ____Yes ____ No If No, Explain:

Does employee have the following in place? | Conservatorship/Guardianship ____ Yes ____ No | Court Order/Divorce Decree ____ Yes ____ No

Does dependent receive SSDI/SSI benefits? ____Yes ____ No If yes, Amount per Month $_____ | Estimated income of dependent from all sources $_____ monthly.

Is dependent currently employed? ____Yes, ____FT ____PT ____ No, Date last employed ____/____/_____

Name and address of dependent's current employer:

Explanations

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: / /

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 / / | Date or Age at "**ONSET**" of the disability: Age: _____ or Date: ____/____/____

The patient is presently: (Circle all applicable) Ambulatory Bed Confined House Confined Hospital Confined Wheelchair Confined

Is patient presently "**incapable**" of self-sustaining employment? ____ Yes ____ No If yes, Date ____/____/____

If yes, by reason of: (Circle all applicable) Intellectual/Developmental Disability Physical Handicap Mental Handicap Other (Explain below)

Please provide the **diagnosis** of the condition(s) causing the incapacitation and provide supportive documentation of the physical and/or functional **limitations** that prevent the dependent from being capable of self support. May attach any written documentation or medical records. **(Medical records/information provided "MUST" be dated within the last 3 months of completing this form)**

Is patient able to do full or part time work? ____ Yes ____ No If yes, from _____/_____/_____

Will patient be capable of self support in the future? ____ Yes ____ No If yes, from _____/_____/_____

Physician's/Surgeon's Name (Print) Address Phone (Including Area Code) ( )

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▶ Physician/Surgeon Signature: Date: / /