Completing the Disabled Dependent Child Certification

Completion of this certification is required for dependents that are coming upon the limiting age and need benefits to continue due to a physical or mental disability. To determine if your dependent qualifies for the Disabled Dependent Benefit, completion of this form by the employee and treating medical provider is required.

Instructions

1. **Employee Statement Pages**: Sections I, II, III, and IV to be completed in their entirety by the employee. **Employee** is required to sign and date in **Section IV. Employee Confirmation, Signature and Date**.

2. Employee to provide an Active/Current copy of the “order/s” (guardianship, conservatorship, court order, divorce decree) employee has in place for the dependent if circled in Section II, Dependent Information and/or an Active/Current copy of the SSDI/SSI Benefit Statement if “Yes” was circled in Section III, Question 5.

3. Employee to provide a copy of the proof of prior coverage documents, **IF, ‘YES’ was circled in Section III, Question 2 - “Did the dependent have a loss of coverage?”**

4. **Medical Provider Statement Page**: To be completed in its entirety by the treating medical provider. **Treating medical provider** is required to confirm, sign and date.

5. Confirm all pages of the certification form have been completed in their entirety **AND make a copy for your files before returning the form. (omission of any information required will cause a delay in the processing of your request)**

6. Return all pages of the fully completed certification form and any additional documents to UnitedHealthcare at the email address or fax number shown below:

   **Dependent Disability Dept.**
   Email: disabled_dep_@uhc.com
   or
   Fax: 844-236-0933

Upon completion of the review process, you and/or your employer group will receive a letter advising of the review determination and coverage dates if applicable. Please allow up to 30 business days for review completion.

*For any additional questions regarding your dependent child’s eligibility benefits, please contact your employer’s Human Resources Department for further assistance.*
# Disabled Dependent Child Certification

**Employee's Statement**
Employee to complete Sections I, II, III & IV. Omitted information will cause delays.

## Section I. Employee Information

<table>
<thead>
<tr>
<th>Group Number</th>
<th>Group Name</th>
</tr>
</thead>
</table>

**PRINT Name:** (First, Middle, Last)

<table>
<thead>
<tr>
<th>Marital Status (Circle One)</th>
<th>Never Married</th>
<th>Married</th>
<th>Divorced</th>
<th>Widowed</th>
<th>Legally Separated</th>
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</thead>
<tbody>
<tr>
<td>Date of Birth</td>
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<td>Member/Subscriber ID#</td>
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<tr>
<td>Relationship to Dependent</td>
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<tr>
<td>Phone: (Including Area Code)</td>
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</tbody>
</table>

**Current Address(es)** (Street, City, State, Zip Code)

- Physical:
- Mailing:
- Email:

## Section II. Dependent Information
Refer to your Member Handbook for who qualifies as an eligible dependent.

<table>
<thead>
<tr>
<th>Circle all applicable orders in place by Employee regarding Dependent.</th>
<th>Guardianship</th>
<th>Court Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>If circled, submit an Active/Current copy of each with this form.</td>
<td>Conservatorship</td>
<td>Divorce Decree</td>
</tr>
</tbody>
</table>

**PRINT Name:** (First, Middle, Last)

<table>
<thead>
<tr>
<th>Marital Status (Circle One)</th>
<th>Never Married</th>
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</table>

**Does the Dependent reside in your household? (Circle one)**
- NO / YES

- If NO, provide reason for different residing address than employee below. (Example: Lives in a group home, medical facility, etc.)

**Currently Resides at:** (Street, City, State, Zip Code)

- Physical:
- Mailing:

## Section III. Financial and Dependent Employment Information

For Employees with a New Employer:

1. Was dependent covered under your prior Employer's Insurance Plan? (Circle One)
   - NO / YES / Not Applicable

   1a. If YES, provide Coverage dates. From: ______/______/______ To: ______/______/______

   1b. If NO, please explain.

2. Did the dependent have a loss of coverage? (Circle One)
   - NO / YES / Not Applicable

   2a. If YES, Submit a copy / proof of prior coverage AND answer coverage questions below:

   - Prior Insurance Carrier:
   - Subscriber's name:
   - Group Name:
   - Coverage dates: From: ______/______/______ To: ______/______/______

3. Does employee provide more than 50% of the dependent's support & maintenance*? (Circle One)
   - NO / YES

   *For example: food, medicine/prescriptions, utility, housing, etc.

Continue to Next Page
### Section III. Financial and Dependent Employment Information (Continued)

4. On what date was the dependent last claimed on your Federal Personal Income Tax Return? Date Last Claimed: __/__/____

4a. Provide further explanation below.

5. Does dependent receive SSDI/SSI benefits? (Circle one) **NO / YES**

5a. If YES, Amount per Month $________, AND submit a copy of current SSDI/SSI Benefit Statement.

6. Is dependent currently working? (Circle One) Full Time / Part Time / Currently Not Working

6a. If dependent is NOT currently working, Date Last Employed: __/__/____

6b. If dependent is currently working, Gross Monthly Income (before taxes) $________

6c. Is dependent's current position with employer eligible for health insurance? (Circle One) **NO / YES**

6c-1. If answered YES, above in 6c, Is dependent carrying "own" health insurance? (Circle one) **NO / YES**

6c-1a. If answered NO, above in 6c-1, provide explanation as to why dependent is not carrying "own" coverage.

6d. Provide Name and address of dependent's current employer below: (Street, City, State, Zip Code)

7. Is dependent currently a student in post-secondary schooling? (Circle one) **NO / YES**

7a. What is the highest grade/level of schooling completed?

   Enrolled: (Circle one) **Full-Time / Part-Time**

   Grade/Level: ____________________

   School type: ____________________

8. Does dependent hold a valid drivers license? (Circle One) **NO / YES**

9. Provide any further Explanations/Additional Information: (attach additional pages if needed)

### Section IV. Employee Confirmation, Signature and Date

I confirm I have completed the Employee's Statement in its entirety. I know it is a crime to fill out this form with information I know is false or leave out information I know is important.

Employee Signature: ____________________________ Date: __/__/____

For processing purposes, Employee's Statement and Medical Provider Statement MUST be submitted together.
<table>
<thead>
<tr>
<th>Medical Provider Statement</th>
<th>(Any fee for the completion of this statement is to be paid by the employee.) Answer all questions below. Omitted information will cause delays.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Name: (First, Middle, Last)</td>
<td>Patient’s Date of Birth: ____________________</td>
</tr>
<tr>
<td>1. What is the primary disabling diagnosis?</td>
<td></td>
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<tr>
<td>2. Age diagnosed with Primary Disabling Diagnosis? (Circle One) From Birth / From _______ Years of Age</td>
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<tr>
<td>3. The patient is presently: (Circle all applicable) Ambulatory Confined To: Bed House Hospital Wheelchair</td>
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<tr>
<td>4. What are the physical/mental/functional limitations related to the primary disabling diagnosis?</td>
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<tr>
<td>5. Are there any other diagnoses currently being treated? (Circle One) NO / YES</td>
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<tr>
<td>5a. If YES, please list:</td>
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</tr>
<tr>
<td>6. Is patient currently able to work? (Circle One) NO / YES</td>
<td>6a. If YES, (Circle One) Full Time / Part Time</td>
</tr>
<tr>
<td>7. Is patient currently able to be self-supportive [does not need financial help from others]? (Circle One) NO / YES</td>
<td></td>
</tr>
<tr>
<td>7a. Is patient currently physically able to care for self? (Circle One) NO / YES</td>
<td></td>
</tr>
<tr>
<td>8. Will patient be capable of self-support in the future? (Circle One) NO / YES If Yes, as of What Date: <strong><strong><strong>/</strong></strong><em>/</em></strong>___</td>
<td></td>
</tr>
<tr>
<td>9. If you answered NO to Questions 6-8 above. Please explain below. (circle all applicable) Intellectual/Developmental Disability Physical Handicap Mental Handicap Other (Explain below)</td>
<td></td>
</tr>
</tbody>
</table>

☐ Documents Attached. Current written documentation or medical records (within the last three (3) months).

I confirm I have completed the Medical Provider Statement in its entirety. 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.

Medical Provider Signature: ____________________________ Date: ______/_____/______

PRINT Medical Provider Name, Address (Street, City, State, Zip Code) Phone: (Including Area Code) (______)