Certification of Dependent Disability Status

Dependent Name: _____

Enrolled Employee (Parent/Guardian) Name: _____

Employer: _____

The above-named dependent has attained age 26 and is eligible for coverage under above referenced employer's health plan due to disability.

A dependent may remain eligible for coverage after attaining the age of 26 when the Eligible Child is:

(1) Not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit (26) was reached; and

(2) Mainly dependent on their enrolled employee parent/guardian for support.

1. Certification of Disability Status ***[To be completed and signed by the covered employee]***

I hereby certify that the following information is true:

My dependent listed above, is age 26 or older and is (1) not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit (26) was reached; and 2) mainly dependent on me, the enrolled employee parent/guardian, for support.

_____ _____

Signature of Covered Employee Date

2. Certification of Disability ***[To be completed and signed by the treating physician of the dependent]***

I hereby certify that the following information is true:

The dependent listed above, is age 26 or older and is (1) under my treatment and has a mental handicap or physical

handicap that began before the age limit (26) was reached.

Date of dependent's disability: Beginning Date: _____ End Date: _____

I hereby certify that the above information is true and complete.

_____ _____

Signature of Attending Physician Date

_____

Printed Name of Attending Physician