# VERIFICATION OF DEPENDENT DISABILITY

State Form 53388 (R / 10-13)
INDIANA STATE PERSONNEL DEPARTMENT

Dependents enrolled in the State of Indiana Health, Dental, Vision, and Life plans can be eligible for coverage until the day the child attains age twenty-six (26). Dependents may be eligible for coverage beyond that age if they are a disabled dependent.

Coverage may be continued beyond the limiting age if the dependent is physically or mentally handicapped. Disabled dependent is defined as a dependent who, prior to age nineteen (19), is both:

(1) Incapable of self-sustaining employment by reason of mental or physical disability, and
(2) Is chiefly dependent upon the insured employee for support and maintenance.

Such child's coverage shall continue if satisfactory evidence of such disability and dependency is received within 120 days after the maximum age is attained. Coverage for the "Dependent" can continue until the employee's coverage is discontinued, the disability no longer exists, or eligibility is not proven.

A Dependent child of the insured employee who attained age nineteen (19) while covered under an eligible Health Care policy and met the disability criteria specified in the insurance contract, is a Dependent eligible for enrollment so long as no break in coverage longer than sixty-three (63) days has occurred immediately prior to enrollment. Proof of disability and prior coverage will be required.

**Annual documentation from a physician is required each year after the child's attainment of the limiting age.** You must complete this form every year within 120 days of the end of the plan year (December 31st) to continue coverage for each of your disabled dependents if the contract definition applies. The insurance carriers may require additional documentation including medical records showing the child's mental or physical disability and/or documentation showing the child is chiefly dependent upon the employee for support and maintenance.

Return this form to the State Personnel Department, Benefits Division; 402 West Washington Street, Room W-161; Indianapolis, IN 46204. You may also fax the form to the Benefits Division at 317-232-3011. Do not send this form directly to the insurance carrier(s). Please print clearly.

Name of employee _____ Telephone number: _____

Employee ID: 10000☐☐☐☐☐☐ E-mail address of employee: _____

Name of dependent _____ Dependent DOB ☐☐-☐☐-☐☐

Relationship to employee _____

Address of dependent _____
*(number and street, city, state, and ZIP code)*

Does this dependent live in the employee's home? ☐ Yes ☐ No

Is the dependent chiefly dependent on the employee for maintenance and support ☐ Yes ☐ No

## AFFIRMATION

The undersigned insured person applies for continuation of disabled dependent's insurance. The insured person understands that continuation of coverage beyond the limiting age specified in the insurance contract is subject to approval by the insurance carriers and that continuous coverage is subject to written request having been made 120 days from the date the disabled child attains the limiting age and thereafter on an annual basis.

In making this application I understand that acceptance of continuation of coverage by the insurance carriers shall in no way affect regular termination provisions of the policy and that such disabled dependent's coverage shall terminate at such time that the insured person's coverage terminates. I hereby certify that the above statements are true to the best of my knowledge and belief. I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

I further authorize any physician, hospital organization, or insurance company to furnish any information required in regard to granting this application. A copy of this authorization shall be considered as valid as the original.

_____ _____

Signature of employee Date *(month, day, year)*

## ATTENDING PHYSICIAN STATEMENT

Diagnosis:_____

_____

Date condition was first diagnosed *(month, day, year)*: _____

Is patient still under your care? ☐ Yes ☐ No

Frequency of treatments ☐ Monthly ☐ Weekly ☐ As Needed

How long has incapacity existed?_____

How long is incapacity expected to last?_____

Is patient capable of self-sustaining employment? ☐ Yes ☐ No

Comments_____

_____

_____

Signature of Attending Physician *(Required)* Degree Date *(month, day, year)*

_____

Printed Name of Physician

_____

Address *(number and street)* City State ZIP Code