Disabled Dependent Procedures

PLEASE READ CAREFULLY

Enclosed is the application necessary to file a request disabled dependent coverage if you have a dependent child who is disabled and is over age 26.

In order for your disabled dependent to covered under the EIT Health & Welfare Plan ("Plan"), you must maintain your Health & Welfare coverage and your child must rely on you or your spouse for more than 50% of his or her financial support and normally reside in your home. The child is considered disabled if he or she is so severely impaired, physically or mentally, that he or she cannot perform in school or at work without assistance, and he or she is not capable of self-support. The impairment must be considered permanent or expected to last at least 12 months. The determination must be based on medical evidence. The child is not considered disabled if disability is solely due to alcoholism or drug addiction.

A completed application consists of the following:

- **Disabled Dependent Coverage Application**
  - Section 1: Must be completed by you
  - Section 2: Must be completed by your child's attending physician
- **Disabled Dependent Affidavit** *(must be notarized by a Notary Public)*
- **Copy of most current insurance or Medicare Card** *(if covered by another group plan or Medicare)*

If approved, we will periodically request documentation to support your dependent's continued condition(s) that prevent them from supporting themselves, this may include a detailed statement from your dependent's physician outlining the nature of the medical condition(s) that incapacitates your child.

Additionally, the attached Disabled Dependent Affidavit attesting that your child is not capable of self-support and that you provide more than 50% of his or her support must be completed and returned to the Fund Office. The affidavit must be signed and your signature must be witnessed by a notary public.

If you have any questions relating to any of these documents, please feel free to reach out to our Medical Department at 312-782-5442.

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Disabled Dependent Coverage Application

Section 1: Participant – *To be completed by you.*

Name:	**SSN:**	**Birth Date:**
Street Address:		**Apt #:**
City:	**State:**	**Zip Code:**
Cell Phone: ( )	**Home Phone: ( )**	**E-mail:**
Employer:	**Occupation:**	

☐ Please check box if the address indicated above is a new address

Dependent Information: *Please complete the section below with your disabled dependent's information*

Dependent Name:	**Birth Date:**

Are insurance benefits provided for this dependent by any other group plan, including Medicare? ☐ *Yes ☐ No
**If yes, please provide a copy of the most current insurance card*

Signature: *Please read carefully. Sign and date below*

I hereby certify that these statements are true and complete to the best of my knowledge and I understand that their validity is one of the conditions of coverage. Any person who knowingly and with the intent to defraud any insurance company Employee benefit plan or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act which is a crime. In New York, the person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. In California, any person who knowingly files a statement of claim containing any false information or misleading information is subject to criminal and civil penalties.

Participant Signature: _____ **Date:** _____

Section 2: Attending Physician's Statement – *To be completed by your doctor. You are responsible for any cost associated with the completion of this form.*

Diagnosis

Primary:	**ICD.9**
Secondary:	**ICD.9**

Objective Findings *(which substantiate or contribute to this patient's condition including results of x-rays, MRIs, EKGs, etc.)*:

Subjective Symptoms:

Treatment

Does this condition require regular medical treatment? ☐ Yes ☐ No **If No, explain:*	**Date of first visit/treatment for this condition:**
Frequency of visits/treatment: ☐ Weekly ☐ Monthly ☐ Other: _____	**Date of most recent visit/treatment for this condition:**

Progress

Patient has:		Patient is:	
☐ Recovered	☐ Not Changed	☐ Ambulatory	☐ Home/Institution Confined
☐ Improved	☐ Regressed	☐ Wheelchair Confined	☐ Other:

In your opinion, will this patient become self-sufficient in the future? ☐ Yes ☐ No

Physical Impairment: *Please select ONE below.*

- ☐ No limitation of functional capacity; capable of any work
- ☐ Slight limitation of functional capacity; capable of light work
- ☐ Moderate limitation of functional capacity; capable of minimal work
- ☐ Severe limitation of functional capacity; incapable of minimal work

Mental/Nervous Impairment: *Please select ONE below.*

- ☐ Patient is able to function under stress and engage in interpersonal relationships *(no limitations)*
- ☐ Patient is able to function in situations and engage in most interpersonal relationships *(slight limitations)*
- ☐ Patient is unable to engage in interpersonal relationships *(marked limitations)*
- ☐ Patient has significant loss of psychological, physiological, personal and social adjustments *(severe limitations)*

Prognosis: *Please answer ALL questions.*

Is the patient currently disabled?	☐ Yes	☐ No
Is patient prevented from doing any substantial work?	☐ Yes	☐ No
Is this disability expected to last for at least 12 months?	☐ Yes	☐ No
Do you expect a fundamental or marked change in the future?	☐ Yes	☐ No

Remarks:

Any additional pertinent information?

Physician Information:

Physician Name:		
Street Address:		
City:	**State:**	**Zip Code:**
Phone:	**Fax:**	
Physician's Signature:	**Date:**	

Return your completed Disabled Dependent Coverage Application to:

Disabled Dependent Affidavit

I hereby certify that is my dependent child and that _____ is incapable of self-support because of a documented handicap.

Please mark each that apply.

- ☐ Physical handicap
- ☐ Mental handicap

I further certify that because of his/her condition, he/she must rely on me or my spouse for more than 50% of his/her financial support. Please indicate if you claim him/her on your annual tax return filed with the Internal Revenue Service.

- ☐ Claim
- ☐ Do not claim *(please provide reason below)*

_____

_____

Are insurance benefits provided for this dependent by any other group plan, including Medicare or Medicaid?

- ☐ No
- ☐ Yes, *please provide a copy of the most current insurance card or Medicare card*

_____ _____

Your Printed Name Your Social Security Number

_____ _____

Your Signature Date

Sworn to before me

On this ____ day of _____ in the year of _____

_____

Notary Public

Return your completed Disabled Dependent Affidavit to:

EIT BENEFIT FUNDS • 6195 West 115th Street, Alsip, IL 60803 • (312) 782-5442 • Fax (312) 782-4431 • www.fundoffice.org