EmblemHealth®

# Disability Status Request Form

Return form and requested documents to: PO Box 2820, New York, NY 10116-2820

BY COMPLETING THIS FORM THE SUBSCRIBER IS REQUESTING COVERAGE BEYOND THE NORMAL LIMITING AGE FOR AN ADULT DEPENDENT WHO IS INCAPABLE OF SELF-SUSTAINING EMPLOYMENT. Please note that we will not be able to continue coverage for your dependent unless we receive, review and approve your paperwork within 31 days of your dependent reaching the limiting age.

## SUBSCRIBER INFORMATION

| Subscriber ID Number | Subscriber Name | | Phone Number* | | |
|---|---|---|---|---|---|
| Address of Subscriber (Number and Street) | Apt | City | | State | ZIP Code |
| Social Security Number | ☐ **"Go Paperless" and Save Trees!**† | Email Address | | | |

*I understand that the phone numbers I provided on this form may be used by EmblemHealth or any of its contracted parties to contact me about my account, my health benefit plan or related programs, or services provided to me.

† By electing "Go Paperless," you will receive claim statements and some other EmblemHealth letters by e-mail instead of paper mail. You will be able to view your Explanation of Benefits (EOBs) under the Claims section of the EmblemHealth Web site when you sign on. Your enrollment in the "Go Paperless" option will continue as long as your account remains active or until you choose to discontinue this option.

## DEPENDENT INFORMATION

| Dependent ID Number | Social Security Number | Dependent Name | Dependent Date of Birth | Sex |
|---|---|---|---|---|
| | | | | ☐ Male ☐ Female |

| Dependent Relationship to Subscriber | Dependent Marital Status |
|---|---|
| ☐ Son ☐ Daughter ☐ Other _____ | ☐ Single ☐ Widowed ☐ Married ☐ Divorced |

| | | |
|---|---|---|
| The dependent listed above is the unmarried child, stepchild or adoptive child of my spouse or myself and is at least the age of 26. | ☐ YES | ☐ NO |
| The dependent listed above resides with me or my spouse. | ☐ YES | ☐ NO |
| Has the dependent listed above ever been institutionalized?<br>If Yes, give name and address of institution _____<br>_____<br>Period of Confinement (dates) _____ | ☐ YES | ☐ NO |
| Was the dependent ever employed for wages?<br>Presently working/last worked at _____ Hours per week _____ | ☐ YES | ☐ NO |
| Is the dependent eligible for care under Medicare? | ☐ YES | ☐ NO |
| Has the dependent been found disabled and is eligible for supplemental security income (SSI) or social security disability insurance (SSDI)? (If yes, documentation is required to evaluate disabled dependent coverage. Example: Notice of award letter) | ☐ YES | ☐ NO |

**IMPORTANT: This form will not be processed without a physician's summary of the dependent's condition (see reverse for details). Failure to submit the requested documents may result in a delay, denial or termination of coverage for the above-named dependent.**

I certify that I have carefully and fully read the important information on the next page of this form. I also certify that the statements and answers given are complete and correct to the best of my knowledge and belief. No information required to be given, either expressly or by implication, has been knowingly withheld. I have provided supportive documentation on my dependent's disability as requested above and I am aware that without proper documentation coverage may be denied. I am also aware that additional information may be required to make a determination of coverage and that presenting this documentation does not imply automatic coverage.

I agree to promptly advise EmblemHealth within 30 days of any change that affects the young adult's eligibility. **Any person who knowingly and with intent to defraud any insurance company or 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 insurance act, which is a crime, and 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.**

Subscriber Signature _____ Date _____

Your completed paperwork is required within 31 days of your dependent reaching the terminating age. Completed paperwork includes this form and a physician's summary.

**The PHYSICIAN'S SUMMARY must be on the physician's office stationery and signed by your dependent's doctor.**
It must include:

- The specific nature of the condition
- Signs and symptoms associated with the condition
- The date such condition commenced; and
- A recent evaluation (within six months) that demonstrates how your dependent's condition prevents any form of self-sustaining employment and that accommodation is not possible
- Physician's contact information including telephone and fax numbers – PRINTED CLEARLY.

**FOR NEW ENROLLMENTS ONLY:** The subscriber must provide evidence that the dependent has had continuous health plan coverage, group or individual, prior to attaining the limiting age and the coverage remains in effect.
You must attach a certificate of creditable coverage or evidence of prior coverage with this request.

According to New York State Insurance Law, continued coverage for your dependent may be available, if he or she:

- Is not married
- Suffers from mental illness, developmental disability[1] (as defined in the New York Mental Hygiene Law), or physical disability
- Had such a condition before reaching the age at which dependent coverage would otherwise end
- Is not capable of self-sustaining employment[*] due to the condition, and proof of this is sent to us within 31 days of reaching the coverage termination age.

[1] **Developmental Disability:** This term refers to a disability of a person that:

a. (1) Is attributable to mental handicap, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia or autism;

(2) Is attributable to any condition of a person found to be closely related to mental handicap because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of a mentally handicap person or requires treatment and services similar to those required for such person; or

(3) Is attributable to dyslexia resulting from a disability described in subparagraph (1) or (2) of this paragraph

b. Originates before such person attains age 22;

c. Has continued or can be expected to continue indefinitely; and

d. Constitutes a substantial handicap to such person's ability to function normally in society.

[*] The inability to find employment or a reduction in work capability is not, in itself, evidence of eligibility. If a mentally ill, developmentally disabled, or physically disabled dependent is working, the extent of his or her earning capacity will be evaluated. He/she must be chiefly dependent upon the subscriber for support and maintenance.

This process relates only to determinations of eligibility for health coverage beyond the normal limiting age for a dependent child who is incapable of self-sustaining employment due to mental illness, developmental disability, mental handicap or a physical disability. A finding by EmblemHealth that the dependent child qualifies as a dependent incapable of self-sustaining employment pursuant to the submission of a Disability Status Request Form does not mean that the dependent is considered disabled by EmblemHealth for any other purpose.