Kansas City

Disabled Dependent Certification

Section 1: Subscriber Information

Full Name of Subscriber (last, first, middle)		Subscriber ID	
Group Name	Group Number	Phone Number	
Address	City	State	Zip Code

.

Section 2: Dependent Information

Full Name of Disabled Dependent (last, first, middle)		Date of Birth
Dependent Social Security Number	Relationship to Subscriber	Marital Status ☐ Married ☐ Single
Nature of disability		Date of disability

Is the Dependent covered by any other Health Coverage or Insurance? ☐ Yes ☐ No

If yes, please provide the following information below:

Name of Insurer	Subscriber ID	Customer Service Number on ID Card	
Address of Insurer on ID Card	City	State	Zip Code

.

Section 3: Social Security Information

Has the dependent been declared disabled by the Social Security Administration?

☐ Yes - Please provide SSDI or SSI document/Award of **Total** Disability letter and provide subscriber signature on Section 6 of this form and STOP

- If the SSA has made a determination of partial disability, please provide documentation and continue to Section 4.

☐ No – Continue to Section 4.

Kansas City

Section 4: Guardianship Information

Has the dependent been placed under Legal Guardianship of the Subscriber or the Subscriber's Spouse by a court?

☐ Yes – Please provide an active court order and provide subscriber signature on Section 6 of this form and STOP

☐ No – Continue to Section 5.

Section 5: Physician Attestation (Required if Section 3 and Section 4 are not satisfied)

The following must be completed, signed, and certified by the dependent's current actively licensed Physician.

Physician Name	NPI number		
Physician Mailing Address	City	State	Zip
Telephone #	Fax #		

Date of Patient's last exam:	Is this disability temporary or permanent? ☐ Temporary ☐ Permanent	If temporary, estimated duration
Diagnosis of condition causing disability; Indicate the severity:		
Is Dependent be capable of self-sustaining support today. ☐ Yes ☐ No	Will the Dependent be capable of self-sustaining support in the future? ☐ **Yes** ☐ No If yes, when?	

Physician Signature and Attestation to the following:
I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. I understand that the inability to find employment or a reduction in work force is not evidence of a disability. My signature attests that the above statements are true and if requested, I can provide further substantiating documentation to support the dependent's physical or mental disability that causes them to be incapable of self-sustaining support at this time.

Physician Signature: _____ Date: _____

Physician Printed Name: _____

Kansas City

Section 6: Subscriber Signature

Subscriber Signature and Attestation to the following:

I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. I hereby certify and attest that the dependent identified in this form in section 2 meets the following criteria;

1. The dependent became disabled before reaching the age of 26; and
2. Meets the Relationship Test outlined below as prescribed by IRS Code § 152; and

   An individual bears a relationship to the subscriber if the individual is any of the following to the subscriber;

   - Child, or descendant of a child
   - Brother, sister, step-brother or step-sister
   - Father, mother, or ancestor of either
   - Step-father or step-mother
   - Son or daughter of a brother or sister of subscriber
   - Brother or sister of the father or mother of the subscriber
   - Son-in-law, daughter-in-law, mother-in-law, father-in-law, brother-in-law or sister-in-law

3. Is incapable of self-sustaining employment due to a mental or physical disability; and
4. The dependent relies primarily (more than 50%) upon Subscriber (and/or Subscriber's spouse) for support and maintenance.

I understand I may be required to produce this information and attest to the status of the dependent annually.

Subscriber Signature: _____ Date: _____