Meritain Health: Eligibility
PO Box 853921
Richardson, TX 75085-3921

Disabled Dependent Form

To help us properly handle claims for a disabled dependent, **please complete this page and the first section on the next page. Then have the dependent's physician complete the remainder of the form. It is important that we receive this form for any disabled dependent who would otherwise not be covered under the plan due to their age.**

Once complete, please submit both pages by:

- Mailing them to the address above;
- Faxing them to: **1.716.541.6672**; or,
- Taking a picture of them, and emailing them to: **forms.direct@meritain.com.**

EMPLOYEE INFORMATION		
Employee name	Employee date of birth	Employee Member ID or Social Security #
Group name *(your employer)* **Beacon Health System**	Group number*(if you already have an ID Card from Meritain Health)* **12727**	

DEPENDENT INFORMATION		
Dependent name	Dependent date of birth	Dependent relationship to employee

Is the dependent unable to be self-supporting? ❑ YES ❑ NO

Do you claim this person as a dependent for federal income tax purposes? ❑ YES ❑ NO

Does this dependent reside in your household? ❑ YES ❑ NO

If NO, where do they live? _____

Do you regularly provide more than one-half the financial support for this dependent? ❑ YES ❑ NO

If NO, please explain. _____

Was the dependent previously covered under the employee's plan? ❑ YES ❑ NO

If YES, please provide the name and phone number of the prior carrier, along with the dependent's effective dates.

_____

Is the dependent covered by any other insurance, or eligible for any privately or publicly funded health benefits? ❑ YES ❑ NO

If YES, please explain. _____

Does the dependent attend school or a training/custodial care facility? ❑ YES ❑ NO

If YES, please provide the name of the school / facility, the dates of attendance and the education level if applicable.

_____

Does this dependent work, or have they been recently working? ❑ YES ❑ NO

If YES, please provide the employer name, the number of hours worked per week, the hourly wage, and a brief description of duties.

_____

_____

DON'T FORGET:

Sign the *Employee Acknowledgement and Release of Information* section on the next page, and then have the dependent's physician complete the remainder of the form.

EMPLOYEE ACKNOWLEDGEMENT AND RELEASE OF INFORMATION

In regards to: _____

Print dependent's name

I certify that the information I have set forth in this application is true and correct to the best of my knowledge. No information has been knowingly withheld or omitted concerning my dependents or me. I understand that providing false information in this application is a crime and may result in the denial of claims or cancellation of coverage. In addition I may be subject to civil and/or criminal penalties.

To all healthcare providers: You are hereby authorized to provide Meritain Health with information concerning health care advice, treatment or supplies provided to the patient (including that relating to mental illness and/or AIDS/ARC/HIV). They will use this information to evaluate a request for coverage. This authorization is valid for the term of the plan under which a claim has been submitted. I understand that I have the right to receive a copy of this authorization upon request, and I agree that a photographic or electronic copy of this authorization is as valid as the original.

_____

Employee signature | Print employee name | Date

THIS SECTION TO BE COMPLETED BY THE DEPENDENT'S PHYSICIAN

Diagnosis(es) and description		
Objective findings and remarks that substantiate classification as a disability		
Date of the onset of the disability(ies)	ICD 10 Code(s)	Social Security disability listing number(s)*
Physician Address, City, State, ZIP		Physician phone (including area code)

**Social Security disability listings can be found at www.ssa.gov/disability/professionals/bluebook. Using the appropriate set of guidelines for adults or children, select the affected body system(s) and identify the appropriate listing number based on the descriptions. Note: Satisfying the Social Security listing level impairment requirements does not ensure a determination of disability under the individual's plan. Guidelines are only used as a means to collect appropriate clinical information.*

_____

Physician signature | Print physician name | Date