

## DISABLED DEPENDENT APPLICATION

Please note that in order for a dependent to apply for disabled dependent coverage, they must meet one of the following conditions:

- Became mentally or physically incapable of earning their own living prior to age 19; or
- Became permanently and totally disabled and became so on or after age 19 and is under age 26. These dependents will only be covered until the last day of the month they turn 26.

If your dependent meets one of these two requirements, we have listed below information for you to return to the GIC so that a decision can be made on your application. If your dependent is working, please include a copy of their latest earnings statement.

### **INFORMATION FROM THE INSURED PARENT**

The insured parent must complete the “*Statement From Insured Parent For Disabled Dependent Coverage*” (page 1 of 2). Please answer all questions completely so that we can process your application as quickly as possible.

### **INFORMATION FROM THE DEPENDENT’S PERSONAL PHYSICIAN**

Please have the Physician’s Statement (page 2 of 2) completed by the dependent’s personal physician; the physician must be licensed to practice medicine in Massachusetts or the state in which you reside.

Please return the entire completed application to us. You can expect to have a response within four to six weeks of the GIC receiving your completed application. If you have any questions you can contact us at (617) 727-2310.

**STATEMENT FROM INSURED PARENT FOR DISABLED DEPENDENT COVERAGE**

*Please complete all questions. Incomplete forms will be returned.*

Full Name of Dependent \_\_\_\_\_

Dependent's Date of Birth \_\_\_\_\_ Dependent's Soc. Sec. Number \_\_\_\_\_

Dependent's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Dependent's Marital Status \_\_\_\_\_

Full Name of Insured \_\_\_\_\_

Insured email address \_\_\_\_\_

Insured Phone Number \_\_\_\_\_

Insured's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Social Security Number \_\_\_\_\_

Date Dependent Became Totally Disabled \_\_\_\_\_

Is your dependent working? Yes \_\_\_\_\_ No \_\_\_\_\_

Is yes, indicate name of employer \_\_\_\_\_

Indicate annual salary \_\_\_\_\_

If the dependent is over age 19, have they had health insurance coverage from age 19 to the present?

YES \_\_\_\_\_ No \_\_\_\_\_

If YES, please provide the following:

Name of Insurance Carrier \_\_\_\_\_

Name of Employer \_\_\_\_\_

The effective date of coverage \_\_\_\_\_

Is coverage still in effect? Yes \_\_\_\_\_ No \_\_\_\_\_

If No, when was coverage cancelled and why? \_\_\_\_\_

If No, please provide the following:

Is your dependent eligible for Medicare Benefits? Yes \_\_\_\_\_ No \_\_\_\_\_ Never Applied for Medicare \_\_\_\_\_

*If YES, please include a photocopy of the Medicare Claim Card*

*If NO, please include a letter from your local Social Security Office advising of the reason the dependent is not eligible for Medicare benefits.*

Please read and sign the following statement and if the dependent is capable, please also have the dependent sign.

*I hereby apply for disabled dependent coverage and agree to periodic independent physician examinations as requested by the GIC. I hereby certify under the pains and penalties of perjury that all statements I have made on this form are true. I understand that if I misrepresent or provide false or incomplete information on this form, my GIC coverage may be terminated (possibly retroactively), in addition to other legal remedies and financial consequences, at the GIC's discretion.*

Signature of Insured Parent \_\_\_\_\_

Date \_\_\_\_\_

Signature of Dependent \_\_\_\_\_

Date \_\_\_\_\_

**PHYSICIAN'S STATEMENT FROM ATTENDING PHYSICIAN**

*Please complete all questions. Incomplete forms will be returned.*

Insured Parent's Name \_\_\_\_\_

Name of Patient \_\_\_\_\_

Patient's diagnosis and date of illness \_\_\_\_\_

(a) Is the patient currently working? YES \_\_\_\_\_ NO \_\_\_\_\_

(b) Is the patient currently capable of self support YES \_\_\_\_\_ NO \_\_\_\_\_

(c) If NO to question b is there any potential that the patient will eventually be capable of self-support?  
YES \_\_\_\_\_ NO \_\_\_\_\_

(d) If YES to question c, please provide your best estimate of when the patient will be capable of self-support. \_\_\_\_\_

Date of onset of disability (the inability to support themselves). \_\_\_\_\_

How long have you been treating this patient for the diagnosis indicated above? State other diagnosis if necessary.

Include first and most recent visits. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe your treatment plan including a prognosis and goals for this patient in as much detail as possible and, if the patient is enrolled in a vocational training, rehabilitation or similar program, include goals and timetables that have been established for the program. (Attach other sheets as necessary.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Under the pains and penalties of perjury, I attest that all statements I have made on this form are true.*

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Data (please print or type the following information): \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone No \_\_\_\_\_

*Insured: Mail pages 1 and 2 together to the GIC at the address below. Keep a copy for your records.*

Commonwealth of Massachusetts Group Insurance Commission  
P.O. Box 556  
Randolph, MA 02368