INDIANA UNIVERSITY

Certification of Disabled Dependent Eligibility for IU-Sponsored Health Care Plans

HUMAN RESOURCES

IMPORTANT INFORMATION—PLEASE READ BEFORE COMPLETING THIS FORM

Dependents enrolled in an IU-sponsored medical and/or dental plan are eligible for coverage until the end of the month in which he/she turns age twenty-six (26). Dependents may be eligible for coverage beyond age 26 if they qualify for disabled dependent eligibility.

For the purposes of determining eligibility for IU-sponsored medical and dental coverage, a dependent qualifies for disabled dependent eligibility if he/she:

(1) is fully disabled, that is, incapable of engaging in self-sustaining employment because of a mental or physical disability; and
(2) is dependent on the employee for support and maintenance and does not have personal resources sufficient to be self-supporting (for example, trust funds or settlements); and
(3) is unmarried; and
(4) is covered under the employee's IU-sponsored health plan at the time he/she reaches age 26.

Coverage for the disabled dependent will continue until the employee's coverage is discontinued, the disability no longer exists, or eligibility is not proven. Proof that the child is fullly disabled must be submitted no later than 30 days prior to the date that the dependent's coverage would have ceased and upon request by the university. **Recertification, including documentation from a physician, will be required at reasonable intervals** to show the dependent continues to qualify for disabled dependent eligibility.

THIS IS A(N): ☐ Initial Certification ☐ Recertification

SECTION 1 To be Completed by Employee	
Employee Name:	**University 10-Digit ID:**
Campus:	**Phone:**
Email:	
Current IU Health Care Plan(s): ☐ Anthem PPO $500 Deductible ☐ Anthem PPO HDHP ☐ IU Health HDHP ☐ IU Dental Plan	
Dependent Name:	**Date of Birth:**
Relationship to Employee: ☐ Biological or Adopted Child ☐ Stepchild ☐ Unlimited Guardianship	
Is this dependent: ☐ Single ☐ Married ☐ Divorced	
Does this dependent live in the employee's household? ☐ Yes ☐ No	
Does this dependent rely on the employee for financial maintenance and support? ☐ Yes ☐ No	
Is this dependent employed: ☐ Full-time ☐ Part-time (_____ hours per week) ☐ Not Employed	

(continued reverse side)

Employee Authorization

I certify that the information I have provided on this certification is true and complete. I understand that any false information or statements will be grounds for Indiana University to void my health plan coverage and/or terminate my employment.

I certify that this dependent meets IU's eligibility requirements for disabled dependent coverage, that is, the dependent:

- is fully disabled, and is incapable of engaging in self-sustaining employment because of a mental or physical disability;
- is dependent on me for financial support and maintenance, and does not have personal resources sufficient to be self-supporting (for example, trust funds or settlements); and
- is unmarried; and
- is covered under my IU-sponsored health plan at the time he/she reaches age 26.

I further authorize any physician, hospital organization, or insurance company to furnish any information required in regard to completion of this certification. A copy of this certification and authorization shall be considered as valid as the original.

Employee Printed Name

X
Employee Signature | **Date:**

SECTION 2 To be Completed by Physician

Dependent (Patient) Name: | **Date of Birth:**

Diagnosis:

Date condition was first diagnosed (mm/dd/yyyy)**:**

Is patient still under your care? ☐ Yes ☐ No | **Frequency of treatments:** ☐ Monthly ☐ Weekly ☐ As Needed

How long is the disability expected to last? ☐ Temporary (Explain: _____) ☐ Permanent

Is patient capable of self-sustaining employment? ☐ Yes ☐ No

Comments:

Physician Printed Name:

Physician Address:

X
Physician's Signature: | **Date:**

For questions contact IU Human Resources at askhr@iu.edu or (812) 856-1234. This form certifying that the child is fully disabled, along with any supporting documentation, must be submitted for review no later than 30 days prior to the date that coverage as a dependent would have ceased.

Submit completed form to askhr@iu.edu, **fax to** (812) 855-3409, or
mail to IU Human Resources, Poplars E165, 400 E. 7th Street, Bloomington, IN 47405-3085

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