INDIANA UNIVERSITY
HUMAN RESOURCES

IU-SPONSORED HEALTH CARE PLANS

CERTIFICATION OF DISABLED DEPENDENT ELIGIBILITY

This is a(an): ☐ Initial Certification ☐ Recertification

EMPLOYEE INFORMATION:			
Employee Name:		**10-Digit ID:**	
Address:	**City:**	**State:**	**Zip:**
Campus:	**Campus Phone:**	**Email:**	
Current IU-Sponsored Health Care Plan(s):	☐ Anthem PPO $500 Deductible ☐ IU Health HDHP	☐ Anthem PPO HDHP ☐ IU Dental Plan	

DISABLED DEPENDENT CHILD INFORMATION:	
Dependent Name (Last, First, M.I.)**:**	**Date of Birth:**

Relationship to Employee: ☐ Biological or Adopted Child ☐ Stepchild ☐ Unlimited Guardianship

Is this dependent child: ☐ Single ☐ Married ☐ Divorced

Is this dependent child employed: ☐ Full-time ☐ Part-time (_____ hours per week) ☐ Not Employed

Income Tax Status:

Was this dependent child claimed as a dependent on the employee/employee's spouse's Federal Income Tax filing for 2017? ☐ Yes ☐ No

If no, would the dependent qualify to be claimed? ☐ Yes ☐ No Explain: _____

_____

_____

Will this dependent be claimed as a dependent on the employee's/employee's spouse's 2018 Federal Income Tax filing? ☐ Yes ☐ No

Has anyone else claimed this dependent for Federal Income Tax purposes? ☐ Yes ☐ No If Yes, explain: _____

_____

_____

Is this dependent legally residing in the employee's household? ☐ Yes ☐ No

If no, where is this dependent residing? _____

Is this dependent presently insured by: ☐ Medicare ☐ Medicaid ☐ Other Medical Plan ☐ No Other Plan

If yes, list Health Plan and ID#: _____

Does this dependent have personal resources (settlement, trust fund, etc.) that may provide financial support? ☐ Yes ☐ No

If yes, please explain: _____

Reverse side of this form must be completed and signed by the dependent's physician.

PRINT RESET SAVE

PHYSICIAN STATEMENT:

Employee Name:	Dependent Name:

The diagnosis of the disabled dependent is: _____

_____

The dependent's disability has been continuous since: _____ / _____ / _____
Month Day Year

Describe symptoms that prevent the dependent from engaging in self-sustaining employment in detail (i.e. extent of learning disability, etc.)

_____

_____

_____

Is the dependent now incapable of self-sustaining employment because of a physical or mental disability? ☐ Yes ☐ No

Name of Physician (print or type):

Physician's Signature:	Date:

ELIGIBILITY FOR DISABLED DEPENDENT COVERAGE

Dependent children that are eligible for Disabled Child Coverage under an IU-sponsored health plan are those children who are:

- Fully disabled, that is, incapable of engaging in self-sustaining employment because of a mental or physical disability;
- Dependent on the employee for financial support and maintenance;
- Unmarried;
- Covered under the employee's IU-sponsored health plan at the time the maximum age for covered dependents is reached.

EMPLOYEE CERTIFICATION:

I certify that the information I have provided in this application for my disabled dependent child 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 disabled dependent meets IU's Eligibility for Disabled Child Coverage, that is, the child is:

- Fully disabled, and is incapable of engaging in self-sustaining employment because of a mental or physical disability;
- Dependent on me for financial support and maintenance;
- Unmarried; and
- Does not have personal resources sufficient to be self-supporting (for example, trust funds or settlements).

Employee Signature:	Date:

For Questions please call (812) 856-1234. This form, along with any supporting documentation, certifying that the child is fully disabled must be submitted to University Human Resources for review no later than **30 days** prior to the date that coverage as a dependent would have ceased. Proof that the child remains fully disabled and is dependent on the employee for financial support may be required at reasonable intervals.

Return completed form to *askHR@iu.edu*, or
Mail to IU Human Resources - ATTN: Customer Care, Poplars E165, 400 E. 7th Street, Bloomington, IN 47405-3085

PRINT RESET SAVE