INDIANA UNIVERSITY
HUMAN RESOURCES

IU-SPONSORED HEALTH CARE COVERAGE

CERTIFICATION OF DISABLED DEPENDENT ELIGIBILITY

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

EMPLOYEE INFORMATION:

Employee Name: _____ 10-Digit Employee ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Address: _____ City: _____ State: _____ Zip: _____

Campus: _____ Phone: _____ _____ _____ E-mail: _____

Current IU-Sponsored Health Care Plan(s):
☐ Anthem PPO $500 Deductible
☐ Anthem PPO HDHP
☐ IU Health HDHP
☐ IU Dental Plan

DISABLED DEPENDENT CHILD INFORMATION:

Dependent Name (Last, First, MI): _____ Date of Birth: _____ . _____ . _____

1.) **Relationship to Employee**: ☐ Biological or Adopted Child ☐ Stepchild ☐ Unlimited Guardianship

2.) **Is this dependent child**: ☐ Single ☐ Married ☐ Divorced

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

4.) **Income Tax Status**:

Was this dependent claimed as a dependent on the employee or employee's spouse's Federal Income Tax filing for 2016? ☐ 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 or employee's spouse's 2017 Federal Income Tax filing? ☐ Yes ☐ No

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

_____

_____

5.) **Is this dependent legally residing in the employee's household?** ☐ Yes ☐ No

If no, where is this dependent residing? _____

6.) **Is this dependent presently insured by**: ☐ Medicare ☐ Medicaid ☐ Other Medical Plan ☐ No Other Plan

If yes, list Health Plan and ID#: _____

7.) **Does 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.

Clear Form Print Form

PHYSICIAN STATEMENT: (To be completed by the dependent child's physician)

Employee Name: _____ Dependent Name: _____

The diagnosis of the disabled dependent is: _____

_____

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

Indicate the dependent's prognosis for recovery in terms of months or years: _____

Describe symptoms that prevent 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 IU 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