DISABLED ADULT DEPENDENT CERTIFICATION FORM

This form is used to determine if your dependent child meets the eligibility requirements for continued coverage after reaching the age limit (26 years). You may be eligible to continue coverage of your disabled dependent(s) on your health, dental, legal, and/or optional life insurance plan(s), or newly enroll them in coverage on these plans, if not previously eligible. To determine eligibility for coverage, this form must be submitted upon initial enrollment of a disabled dependent and annually thereafter, by August 31st of each benefit plan year, for coverage beginning January 1st of the upcoming benefit plan year.

Note: A separate form must be completed for each disabled dependent.

SUBSCRIBER INFORMATION:

LAST NAME _____ **FIRST NAME** _____ **MIDDLE INITIAL** _____

STATUS: ☐City ☐Schools ☐Retired City ☐Retired Schools ID #: _____

☐PHSA/COBRA Social Security #: _____

DISABLED ADULT DEPENDENT INFORMATION: *(To be completed by the subscriber)*

NAME: _____ **DATE OF BIRTH:** _____
Last Name, First Name MI

RELATIONSHIP TO SUBSCRIBER: ☐Child ☐Sibling ☐Other _____

I hereby certify that the above information is correct to the best of my knowledge and authorize release of any information required for this certification.

_____ _____
SUBSCRIBER SIGNATURE **DATE**

DISABLED ADULT DEPENDENT CERTIFICATION: *(This section must be completed by the dependent's Physician, Psychiatrist or Psychologist. Section must be dated, and include the physician's name, signature, and office stamp.)*

1. **Is the dependent incapable of self-sustaining support and reliant upon another (the subscriber listed above) for their support and maintenance due to disability?** ☐Yes ☐No
2. **Is the disabled adult dependent able to provide 50% or more support for themselves?** ☐Yes ☐No
3. **Dependent's age when disability occurred:** _____
4. **Primary diagnosis:** _____
5. **Nature of disability:** *(Please provide a statement of substantiation to meet the criteria for the Social Security's definition for disability.)*

PHYSICIAN NAME: _____
(Please Print Legibly)

PHYSICIAN SIGNATURE: _____

DATE: _____

SEND COMPLETED FORM TO:

• INTEROFFICE	• EMAIL	• FAX	• MAILING ADDRESS	• PHYSICAL ADDRESS *Plaza Annex (Drop Box available)*
Consolidated Benefits Office	Benefits@vbschools.com	757.263.1123	2512 George Mason Drive Virginia Beach, VA 23456	641 Carriage Hill Road Virginia Beach, VA 23452

Important: If for any reason, voluntary or involuntary, the subscriber or disabled dependent is disenrolled from coverage, and the disabled dependent reaches, or is already beyond, the age of 26 during the time of disenrollment, the disabled dependent is no longer eligible for coverage, even upon re-enrollment of the employee, if applicable.