Statement of Dependent Eligibility Beyond Limiting Age Due to Mental or Physical Disability

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Employee's Statement

Answer all questions below. Omitted information will cause delays.

Name (Print) First	Middle	Last	Social Security Number / /	Date of Birth	☐ Male ☐ Female
Present Address: Street	City	State Zip Code	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Phone (Including Area Code) ( )	

Dependent Information

Name (Print) First	Middle	Last	Date of Birth	☐ Male ☐ Female
Present Address: Street	City	State Zip Code	Marital Status ☐ Single ☐ Married	Relationship to Employee

Name and address of dependent's current employer

Estimated income of dependent from all sources $ _____ monthly	Percentage of support by the employee for the dependent _____ %	☐ Conservatorship/Guardianship ☐ Court ordered/Divorce Decree

Is dependent listed as a dependent in your last Federal Personal Income Tax Return? ☐ Yes ☐ No If No, Explain

Is dependent employed? ☐ Yes ☐ FT ☐ PT ☐ No Date last employed _____

Explanations

I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT. ▶ Signed (Employee)	Date

Physician's/Surgeon's Statement

(Any fee for the completion of this statement is to be paid by the employee.) Answer all questions below. Omitted information will cause delays.

Patient's Name First	Middle	Last	Patient's Date of Birth
Is this dependent presently incapable of self-sustaining employment by reason of: Intellectual/Developmental Disability? ☐ Yes ☐ No; Physical Handicap? ☐ Yes ☐ No; Mental Handicap? ☐ Yes ☐ No; Other (explain) ☐ Yes ☐ No			**Date dependent became incapable of self-sustaining employment.**

Please provide the **diagnosis** of the condition(s)causing the incapacitation and provide supportive documentation of the physical and/or functional **limitations** that prevent the dependent from being capable of self support. May attach any written documentation or medical records.

Is the dependent able to do full or part time work? ☐ No ☐ Yes, From _____ Date	**Will the patient be capable of self support? ☐ No ☐ Yes, From** _____

The patient is presently (check one) ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

Physician's/Surgeon's Name (Print)	Address	Phone (Including Area Code) ( )

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