Application to Request Continuation of Coverage for a Disabled Dependent Child at Age 26 and Over

Human Resources Department
Employee Benefits Division
Email: benefits.hrd@austintexas.gov

SECTION A: EMPLOYEE / RETIREE PERSONAL DATA

SOC SEC NO	LAST NAME	FIRST NAME	MI	BIRTHDATE
ADDRESS		CITY	STATE	ZIP
COUNTY	HOME PHONE	WORK PHONE	CELL PHONE	
EMAIL ADDRESS				

DEPENDENT PERSONAL DATA

SOC SEC NO	LAST NAME	FIRST NAME	MI	BIRTHDATE
ADDRESS		CITY	STATE	ZIP

SECTION B: COVERAGE INFORMATION

(The child must have been enrolled as a participant in a City of Austin health or dental plan on his or her 26th birthday and such coverage must not have lapsed.)

DEPENDENT COVERAGE TO BE CONTINUED ◯ MEDICAL PLAN ◯ DENTAL PLAN

1. Does the individual depend on you for care or support? ◯ Yes ◯ No If yes, what percentage of care or support do you contribute? _________
2. Was dependent claimed as a dependent on your last Federal Income Tax Return? ◯ Yes ◯ No
3. Is the dependent receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)? ◯ Yes ◯ No
   If yes, provide copy of award letter and most recent monthly statement.
4. Is dependent covered by Medicaid? ◯ Yes ◯ No Provide Medicaid Number: _______________ Effective Date: _________
5. Is dependent covered by Medicare? ◯ Yes ◯ No Provide Medicare Number: _______________ Effective Date: __________
   Part A Effective Date: __________ Part B Effective Date: __________

SECTION C: EMPLOYEE / RETIREE STATEMENT

1. Nature of dependents disability: ____
   ____
2. Date of first medical treatment relating to the disability: ______________________________
3. Is the dependent prevented from obtaining gainful full-time employment? ◯ Yes ◯ No
4. Is the dependent currently employed? ◯ Yes ◯ No
5. If yes, give name(s) and address(es) of employer(s), dates of employment, and average work hours per week and earnings:
   ____
   ____
6. If Dependent has ever been under observation, care, or treatment in any hospital, sanitarium, or similar institution on an inpatient basis, please complete the following: Name of hospitals or institutions: ______________________ Date of last treatment of care: _______________ Number of days: ____

Please provide copies of your most recent W-2, and your last 3 years of tax returns, or IRS Form 4506-T (www.irs.gov/pub/irs-pdf-f4506t.pdf)

SECTION D: CERTIFICATION

I certify that the information I have provided is true and correct and that I have not withheld information on this application. I am aware that any misrepresentation may lead to my dismissal or may cause my application to be rejected. I agree to comply with the rules set forth in the plan document(s) and/or insurance contract(s) for the plans offered by the City. I certify that the dependent listed on this application is an eligible dependent as defined in the plan document(s).

All of the information provided in this Application To Request Continuation of Coverage for a Disabled Dependent Child At Age 26 and Over is true and correct based on my personal knowledge.

______________________________________ ______________________

Signature of Employee/Retiree Date Signed

Please submit completed form by email to benefits.hrd@austintexas.gov.

SECTION E: ATTENDING PHYSICIAN'S STATEMENT

1. Is the dependent able to work at any occupation on a full-time basis? ◯ Yes ◯ No
   If no, was the dependent incapacitated from all work prior to reaching age 26 and when did incapacity begin?
   ____

2. Will the dependent by capable of employment in the future? ◯ Yes ◯ No ◯ Questionable
   If yes, give approximate date and the type of employment (sedentary, light duty, etc.) the dependent will be capable of performing, including any limitations or reasonable accommodations that may be required.
   ____
   ____
   ____

3. Nature and extent of incapacity. Please provide complete diagnosis. You may attach a narrative summary relative to the diagnosis/prognosis:
   ____
   ____
   ____
   ____
   ____
   ____

4. Date dependent was last examined: ____________________
   Abnormal findings at time of last examination: ____________________
   Prognosis: ____________________

5. How does condition(s) restrict the dependent's ability to engage in normal activities of daily living that prohibit them from living by themselves?
   ____
   ____

6. Has this disability been diagnosed as permanent? ◯ Yes ◯ No If no, how long will condition last?
   ____

7. Physician Name (print): ____________________

8. Specialty Board Certification: ____________________

9. Physician Signature: ____________________ Date: ____________________
   (Form is invalid without physician's signature and date of signature.)

10. Office Address: ____________________

11. Physician's Phone Number: ____________________ Fax Number: ____________________

INTERNAL USE ONLY

◯ Approved Re-Certification Date ____________________

◯ Denied

Additional Information Required: ____________________

Authorized Signature ____________________ Date Signed ____________________