Disabled Dependent Authorization

Please complete all required Information below and send to Peak Health via mail: Peak Health, 1085 Van Voorhis Rd Suite 300, Morgantown WV 26505 or by fax: (304) 974-3470.

Primary Member Information

Member Name:	**Member ID Number:**
Phone Number:	**Member Date of Birth (MM/DD/YYYY):**
Address:	

Dependent Information

Dependent Name:	**Dependent ID Number:**
Relationship to Member:	**Dependent Date of Birth (MM/DD/YYYY):**
Dependent Address:	
Sex (M/F):	**Dependent Marital Status:**
Date of Disability:	**Nature of Disability:**
Does dependent have any other health insurance (Ex: Medicare)? (Y/N): If yes, provide responses in fields below.	
Other Health Insurance Name:	**Other Health Insurance ID Number:**
Is the other health insurance company primary coverage for the dependent? (Y/N):	

Note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Social Security Disability or Legal Guardianship Supporting Documents

Has the dependent been declared disabled by the Social Security Administration? □ Yes □ No If yes, provide the following: • Copy of SSDI award letter • Copy of most recent monthly SSI Statement and/or • Applicable court order • Completed form with Member signature *(Physician Certification is not required)* If no, provide the following: • Completed form with Member signature • Completed Physician Certification	**or**	Has the dependent been placed in legal guardianship by a court order? □ Yes □ No If yes, provide the following: • Copy of the active legal guardianship court order • Completed form with Member signature *(Physician Certification is not required)* If no, provide the following: • Completed form with Member signature • Completed Physician Certification

I certify/attest that the dependent meets all of the following criteria:

- Dependent became disabled before reaching the maximum age for dependents (26 years old);
- Dependent is unmarried;
- Dependent receives 50% or more of support by his/her parent;
- Dependent has a disability that Is expected to last more than 12 months or is terminal in nature;
- Dependent is incapable of self-sustaining support/employment due to the disability;
- Dependent relies primarily upon the Member (and/or spouse) for support and maintenance; and
- Dependent is not eligible for coverage under another health plan or Medicare or Medicaid (unless federal or state law requires otherwise)

I understand and agree that:

- Disabled dependent eligibility is subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer and Peak Health.
- The information provided in this authorization will be used by Peak Health for the purpose of certifying the above named dependent as disabled for coverage under my health insurance. This authorization to collect all information related to dependent's disability is valid from the date signed until recertification is required.
- I certify that the above information is true and correct to the best of my knowledge, information, and belief. I understand that providing false, inaccurate, or misleading information could result in a recission of coverage, claim denial, and/or legal action against me by my employer or Peak Health.
- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Member Signature: _____ **Date:** _____

Form must be signed to be valid.

Disabled Dependent Physician Certification

Please complete all required Information below and send to Peak Health via mail: Peak Health, 1085 Van Voorhis Rd Suite 300, Morgantown WV or by fax: (304) 974-3470.

It is imperative that this form is completed, signed, and certified by a physician in order to process this application.

Any fee for the completion of this form is the responsibility of the member.
Important note: The inability to find employment or a reduction in employment is NOT conclusive evidence of disabled dependent's eligibility for continuation of coverage.

Dependent Last Name:	**Dependent First Name:**	**Dependent Date of Birth:**

Physician Name:	**Physician Mailing Address:**
Physician Contact Number:	**Physician Fax Number:**
Date of patient's last exam (Must be within past year):	
Disability is Complete 100% **☐ Yes ☐ No**	**Disability is partial: ____%**
Is the disability temporary or permanent: **☐ Temporary ☐ Permanent**	**If temporary, estimated duration:**
Date of Disability:	
Diagnosis causing disability (provide ICD-10 and standard nomenclature of condition):	
Will dependent/patient be capable of self-support? ☐ Yes ☐ No **If yes, when (date)? _____**	

Note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Name of Attending Physician (printed): _____

Signature of Attending Physician: _____ Date: _____

My signature attests that the above statements are true and if requested I can provide further substantiating documentation.