

# PEBTF

150 South 43<sup>rd</sup> Street Suite 1  
Harrisburg, PA 17111-5700

Local: 717-561-4750  
Toll Free 800-522-7279

## PEBTF DISABLED DEPENDENT CERTIFICATION

Note: All information requested below MUST be completed. If more space is needed, please attach a separate sheet

### EMPLOYEE/RETIREE INFORMATION:

Name (First, Middle Initial, Last): \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_ Employee #: \_\_\_\_\_

### DEPENDENT CHILD INFORMATION:

Name (First, Middle Initial, Last): \_\_\_\_\_

1. Date of Birth (MM/DD/YYYY): \_\_\_\_\_
2. Relationship to member:  Child  Step child  Other (specify) \_\_\_\_\_
3. Is Dependent employed?  Yes  No Was Dependent ever employed?  Yes  No
4. If Dependent is/was employed:  Full time  Part time

Employer Name	Dates of Employment	Hours Worked Weekly	Hourly Wage	Description of Duties

5. Does Dependent have other medical coverage?  Yes  No

If yes, please provide name of insurance company and group, certificate or agreement number below:

\_\_\_\_\_

6. Dependent's age when disability occurred: \_\_\_\_\_
7. Is the dependent child currently residing in your household?  Yes  No

If no, please explain below: \_\_\_\_\_

8. Are you or your spouse responsible for more than 50% of the dependent's financial support?  
 Yes  No

9. Was the dependent child claimed on your or your spouse's federal income tax return?  
 Yes  No, please explain \_\_\_\_\_

**If yes, a copy of your return including the signature page must be included when returning the certification.**

**MEMBER'S AUTHORIZATION:** I HEREBY CERTIFY THAT THE ABOVE LISTED INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION. I UNDERSTAND THAT RECERTIFICATION MAY BE REQUESTED IN THE FUTURE.

**NOTE:** Eligibility for benefit coverage as a disabled dependent and continuance of same is based on the nature of disability, duration and prognosis. Disabled dependents are subject to recertification by the PEBTF. Failure to provide the necessary certification when requested to substantiate eligibility will result in the termination of a dependent's coverage. If or when your dependent no longer meets the eligibility requirements shown above, he/she has the right to continue coverage on a self-pay basis for up to 36 months

**Member's Signature** \_\_\_\_\_

**Date signed** \_\_\_\_\_

**PEBTF DISABLED DEPENDENT CERTIFICATION (Continued)**

**THIS SECTION TO BE COMPLETED BY ATTENDING PHYSICIAN**

**Dependent Name:** \_\_\_\_\_

1. Is the dependent capable of being gainfully employed?  Yes  No
2. Does the disability restrict their usual daily activities such as play and/or school or work attendance?  Yes  No
3. When did you first treat the dependent for the disability? \_\_\_\_\_
4. Has the disability existed continuously since before the dependent attained age 26?  Yes  No

5. Diagnosis (please note below):

\_\_\_\_\_

6. Nature of disability (explain in detail the nature, severity and extent of the disability, how the disability affects the dependent's functional abilities, decision making capacity, etc. **Diagnosis alone does not provide sufficient information to support a determination of disability:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Treatment/medication rendered to patient and response to the treatment/medication:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Is dependent's disability considered:  Temporary  Permanent
9. Is the disability considered:  Total disability  Partial disability

10. Physician Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

11. Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please include any/all prior evaluations/assessments the dependent may have had to validate the disability.**