PEBTF

150 South 43rd 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/YYY): _____ 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:

By my signature below, I authorize the release of information requested with respect to this certification. I understand that 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.

By my signature below, I further declare that the above listed information and any supporting documentation submitted herewith is true and correct to the best of my knowledge, information and belief. I also understand that the PEBTF reserves the right to suspend or terminate my PEBTF group health plan coverage if it concludes I have provided false or misleading information in this Certification or in any documentation submitted with this Certification. I further understand that I may be held responsible for costs in the event that it has been determined that the information provided was false.

Member's Signature _____ **Date signed _____**

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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.