**Completing the Disabled Dependent Child Certification**

Completion of this certification is required for dependents that are coming upon the limiting age and need benefits to continue due to a physical or mental disability. To determine if your dependent qualifies for the Disabled Dependent Benefit, completion of this form by the employee and treating medical provider is required.

**Instructions**

1. **Employee Statement Pages:** Sections I, II, III, and IV to be completed in their entirety by the employee. **Employee** is required to sign and date in **Section IV. Employee Confirmation, Signature and Date.**

2. Employee to provide an Active/Current copy of the “order/s” *(guardianship, conservatorship, court order, divorce decree)* employee has in place for the dependent if circled in Section II, Dependent Information and/or an Active/Current copy of the SSDI/SSI Benefit Statement if “Yes” was circled in Section III, Question 5.

3. Employee to provide a copy of the proof of prior coverage documents, **IF, ‘YES’** was circled in Section III, Question 2 - “Did the dependent have a loss of coverage?”

4. **Medical Provider Statement Page:** To be completed in its entirety by the treating medical provider. **Treating medical provider** is required to confirm, sign and date.

5. Confirm all pages of the certification form have been completed in their entirety **AND** make a copy for your files before returning the form. *(omission of any information required will cause a delay in the processing of your request)*

6. Return all pages of the fully completed certification form and any additional documents to UnitedHealthcare at the email address or fax number shown below:

   **Dependent Disability Dept.**
   Email: disabled_dep_@uhc.com
   or
   Fax: 844-236-0933

Upon completion of the review process, you and/or your employer group will receive a letter advising of the review determination and coverage dates if applicable. Please allow up to 30 business days for review completion.

*For any additional questions regarding your dependent child’s eligibility benefits, please contact your employer’s Human Resources Department for further assistance.*
## Employee's Statement

Employee to complete Sections I, II, III & IV. Omitted information will cause delays.

### Section I. Employee Information

<table>
<thead>
<tr>
<th>Group Number</th>
<th>Group Name</th>
</tr>
</thead>
</table>

**PRINT Name:** (First, Middle, Last)

### Marital Status (Circle One)

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Never Married</th>
<th>Married</th>
<th>Divorced</th>
<th>Widowed</th>
<th>Legally Separated</th>
</tr>
</thead>
</table>

- **Date of Birth:** / / 
- **Member/Subscriber ID#:** / / 
- **Relationship to Dependent:** / / 
- **Phone:** (Including Area Code) / / 

**Current Address(es):** (Street, City, State, Zip Code)

**Physical:**

**Mailing:**

**Email:**

### Section II. Dependent Information

Refer to your Member Handbook for who qualifies as an eligible dependent.

- **Circle all applicable** orders in place by Employee regarding Dependent.

- **Guardianship**

- **Conservatorship**

- **Court Order**

**PRINT Name:** (First, Middle, Last) / / 

**Marital Status (Circle One):**

- **Never Married**
- **Married**
- **Divorced**
- **Widowed**
- **Legally Separated**

**Does the Dependent reside in your household?** (Circle one) NO / YES

- **If NO**, provide reason for different residing address than employee below. (Example: Lives in a group home, medical facility, etc.)

**Currently Resides at:** (Street, City, State, Zip Code)

**Physical:**

**Mailing:**

### Section III. Financial and Dependent Employment Information

**For Employees with a New Employer:**

1. **Was dependent covered under your prior Employer's Insurance Plan?** (Circle One) NO / YES / Not Applicable

   - **If YES,** provide Coverage dates. From: / / / To: / / /

   - **If NO,** please explain.

2. **Did the dependent have a loss of coverage?** (Circle One) NO / YES / Not Applicable

   - **If YES,** Submit a copy / proof of prior coverage AND answer coverage questions below:

   **Prior Insurance Carrier:**

   **Subscriber's name:**

   **Group Name:**

   **Coverage dates:** From: / / / To: / / /

3. **Does employee provide more than 50% of the dependent's support & maintenance**? (Circle One) NO / YES

   *For example: food, medicine/prescriptions, utility, housing, etc.*

---

Continue to Next Page
### Section III. Financial and Dependent Employment Information (Continued)

4. On what date was the dependent last claimed on your Federal Personal Income Tax Return? Date Last Claimed: _____/_____/_______

   4a. Provide further explanation below.

5. Does dependent receive SSDI/SSI benefits? (Circle one) NO / YES

   5a. If YES, Amount per Month $_________, AND submit a copy of current SSDI/SSI Benefit Statement.

6. Is dependent currently working? (Circle One) Full Time / Part Time / Currently Not Working

   6a. If dependent is NOT currently working, Date Last Employed: _____/_____/_______

   6b. If dependent is currently working, Gross Monthly Income (before taxes) $___________

   6c. Is dependent's current position with employer eligible for health insurance? (Circle One) NO / YES

   6c-1. If answered YES, above in 6c, Is dependent carrying "own" health insurance? (Circle one) NO / YES

   6c-1a. If answered NO, above in 6c-1, provide explanation as to why dependent is not carrying "own" coverage.

   6d. Provide Name and address of dependent's current employer below: (Street, City, State, Zip Code)

7. Is dependent currently a student in post-secondary schooling? (Circle one) NO / YES

   7a. What is the highest grade/level of schooling completed?

   Enrolled: (Circle one) Full-Time / Part-Time

   Grade/Level: ____________ School type: ____________

8. Does dependent hold a valid driver's license? (Circle One) NO / YES

9. Provide any further Explanations/Additional Information: (attach additional pages if needed)

### Section IV. Employee Confirmation, Signature and Date

I confirm I have completed the Employee's Statement in it's entirety. I know it is a crime to fill out this form with information I know is false or leave out information I know is important.

Employee Signature: ___________________________________________ Date: _____/_____/_______

For processing purposes, Employee's Statement and Medical Provider Statement MUST be submitted together.
## Disabled Dependent Child Certification

**THIS PAGE IS TO BE COMPLETED IN FULL BY THE DEPENDENT’S TREATING MEDICAL PROVIDER ONLY.**

### Medical Provider 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.**

<table>
<thead>
<tr>
<th>Medical Provider Statement</th>
<th>Patient’s Date of Birth / /</th>
</tr>
</thead>
</table>

1. What is the primary disabling diagnosis?

2. Age diagnosed with Primary Disabling Diagnosis? (Circle One) From Birth / From _____ Years of Age

3. The patient is presently: (Circle all applicable) Ambulatory Confined To: Bed House Hospital Wheelchair

4. What are the physical/mental/functional limitations related to the primary disabling diagnosis?

5. Are there any other diagnoses currently being treated? (Circle One) NO / YES

   5a. If YES, please list:

6. Is patient currently able to work? (Circle One) NO / YES

   6a. If YES, (Circle One) Full Time / Part Time

7. Is patient currently able to be self-supportive [does not need financial help from others]? (Circle One) NO / YES

   7a. Is patient currently physically able to care for self? (Circle One) NO / YES

8. Will patient be capable of self-support in the future? (Circle One) NO / YES If Yes, as of What Date: _____/_____/_____

9. If you answered NO to Questions 6-8 above. Please explain below. (circle all applicable)

   - Intellectual/Developmental Disability
   - Physical Handicap
   - Mental Handicap
   - Other (Explain below)

☐ Documents Attached. **Current** written documentation or medical records (within the last three (3) months).

I confirm I have completed the Medical Provider Statement in it’s entirety. I know it is a crime to fill out this form with information I know is false or to leave out information I know is important.

**Medical Provider Signature: ___________________________ Date: _____/_____/_____

PRINT Medical Provider Name, Address (Street, City, State, Zip Code) Phone: (Including Area Code) ( )

For processing purposes, Employee’s Statement and Medical Provider Statement MUST be submitted together.