DISABLED DEPENDENT APPLICATION

PLEASE READ CAREFULLY

The Disabled Dependent Application is to determine if your adult dependent child meets the plan's eligibility requirements for continued coverage after the age limit of 26.

CONDITIONS OF ELIGIBILITY
Under the provisions of the Contract coverage, a dependent who is mentally or physically disabled may continue coverage to any age if all of the following criteria are satisfied:

1. Dependent became disabled before reaching the limiting age (over the age of 26).
2. Dependent must be incapacitated or incapable of self-sustaining employment.

IMPORTANT NOTE
A reduction in work force or the inability to find employment is NOT evidence of eligibility for continuation of coverage.

INSTRUCTIONS

Step 1: Complete all applicable sections of the attached Disabled Dependent Application form.

Step 2: Subscriber must complete and sign the applicable fields.

Step 3: Licensed physician must complete and sign the applicable fields.

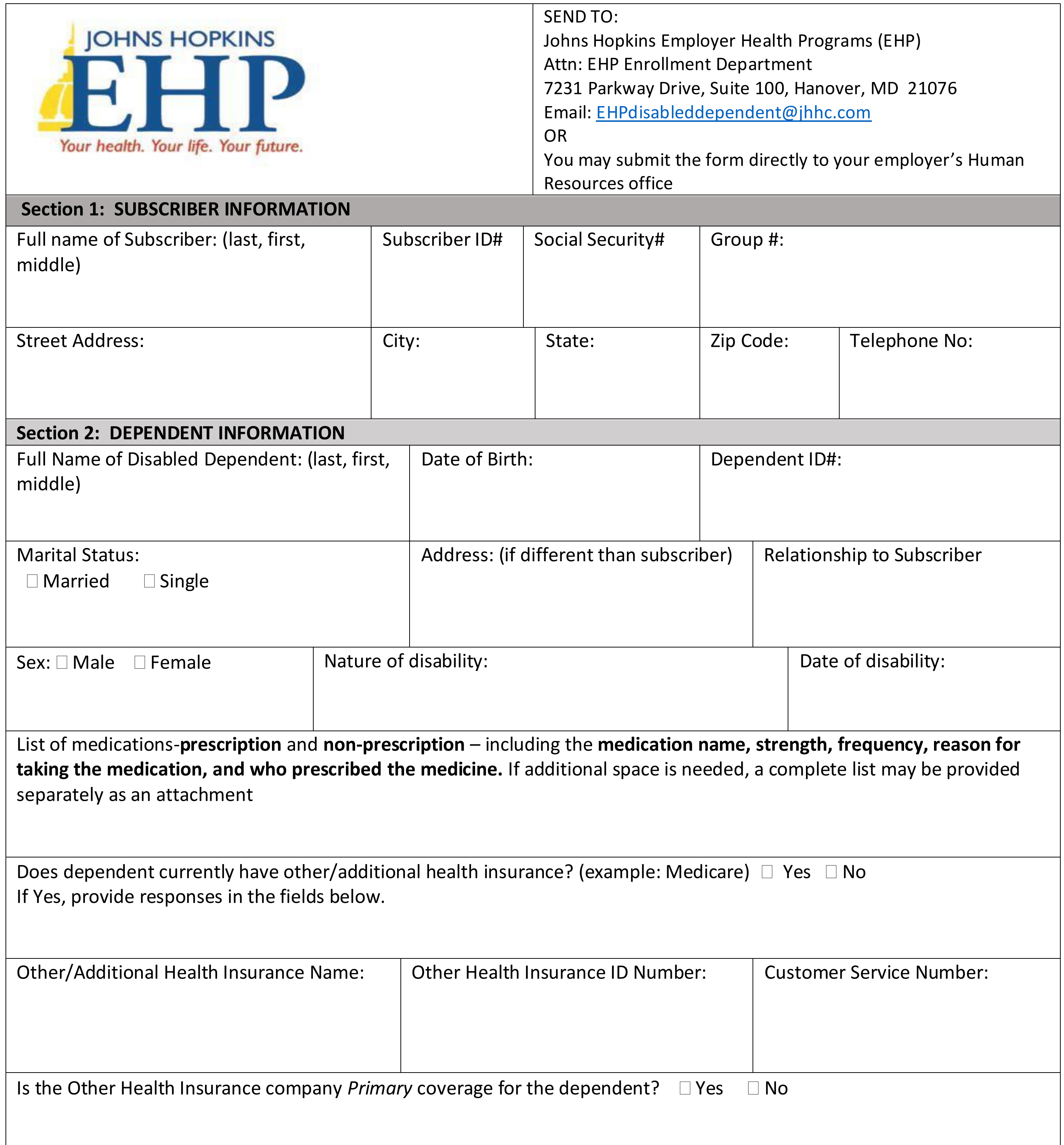
Step 4: Include *one* of the following:

- Copy of active Social Security Disability Insurance (SSDI) Award Letter (where applicable)
- Physician Attestation (where applicable)
  If child has only SSI and not SSDI, the child's physician will need to complete section 4: The Physicians Statement.

Step 5: Send to:

Johns Hopkins Employer Health Programs (EHP)
Attn: EHP Enrollment Department
7231 Parkway Drive, Suite 100, Hanover, MD 21076
Email: EHPdisableddependent@jhhc.com OR
You may submit the form directly to your employers Human Resources office

ALL SECTIONS MUST BE COMPLETED PER INSTRUCTIONS (review carefully)



JOHNS HOPKINS EHP
Your health. Your life. Your future.

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Section 1: SUBSCRIBER INFORMATION

Full name of Subscriber: (last, first, middle)	Subscriber ID#	Social Security#	Group #:	
Street Address:	City:	State:	Zip Code:	Telephone No:

Section 2: DEPENDENT INFORMATION

Full Name of Disabled Dependent: (last, first, middle)	Date of Birth:	Dependent ID#:
Marital Status: ☐ Married ☐ Single	Address: (if different than subscriber)	Relationship to Subscriber
Sex: ☐ Male ☐ Female	Nature of disability:	Date of disability:

List of medications-**prescription** and **non-prescription** – including the **medication name, strength, frequency, reason for taking the medication, and who prescribed the medicine.** If additional space is needed, a complete list may be provided separately as an attachment

Does dependent currently have other/additional health insurance? (example: Medicare) ☐ Yes ☐ No
If Yes, provide responses in the fields below.

Other/Additional Health Insurance Name:	Other Health Insurance ID Number:	Customer Service Number:

Is the Other Health Insurance company *Primary* coverage for the dependent? ☐ Yes ☐ No

**The attending physician's statements regarding disability status are necessary and important for EHP; however, EHP is not bound by the physician's conclusion.

DEPENDENT EDUCATION & TRAINING	
Highest Grade –Level completed:	Date of Completion:
Special Education School Name, City and State (If applicable):	Date of Completion:
Trade/Vocational School Name or Special job training (if applicable):	Date of Completion:

DEPENDENT EMPLOYMENT HISTORY

What is the Dependent's current employment status: □ Employed □Not employed □ Not Applicable

If Employed, provide responses to the following:
Name of Employer:______________________________________

List the type of job(s) (up to 5) held in the 10 years prior to becoming unable to work because of the dependent's medical and/or mental health condition (s), dates jobs held, and the type of duties performed on the job. **If additional space is needed, a complete list may be provided separately as an attachment**

Type of job:	Dates Job Held:	Duties Performed:
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Section 3: SOCIAL SECURITY DISABILITY DOCUMENTS

Has the dependent been declared disabled by the Social Security Administration?

□ **Yes** □ **No**

If **yes**, complete the following:

- Attach a copy of the Active SSDI Award letter and SSI Statement
- Sign on the Subscriber signature line and STOP

If **No**, provide subscriber signature and then continue to **section 4**

**The attending physician's statements regarding disability status are necessary and important for EHP; however, EHP is not bound by the physician's conclusion.

SUBSCRIBER SIGNATURE – must be signed for the form to be valid

Please 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.

I certify/attest that <Dependent’s Name> meets the following criteria:

1. The dependent became disabled before reaching the limiting age (over the age of 26); and
2. Is incapable of self-sustaining employment due to disability; and
3. The dependent relies primarily upon Subscriber (and/or spouse) for support and maintenance.

Subscriber Signature: ______________________________ **Date:**______________________

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

SECTION 4: PHYSICIAN’S INFORMATION– the following must be completed, signed and certified by a physician
IMPORTANT NOTE
A reduction in work force or the inability to find employment is NOT evidence of eligibility for continuation of coverage.

Provider Name:	Provider Mailing Address:	Provider Contact Phone: Fax Number:
Date of patient’s last exam: (The application date and date of the last exam MUST be within the past year)	Disability is Complete 100% ☐ Yes ☐ No	Disability is: Partial_____%

Is this disability request Medical or Mental Health related? ☐ Medical ☐ Mental Health

Please provide the following information **(if applicable)**:

- Copy of dependent’s most recent history and physical which documents the diagnosis and functional limitations of the patient.
- Copy of patient’s psychiatric evaluation, which documents diagnosis and functional limitations of the patient
- List of prescribed medications

Is this disability temporary or permanent? ☐ Temporary ☐ Permanent	If temporary, estimated duration:

Diagnosis causing disability: (provide ICD-10 and standard nomenclature of condition)

Please 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.

**The attending physician’s statements regarding disability status are necessary and important for EHP; however, EHP is not bound by the physician's conclusion.

Physician Name: (Print / Credentials): ____

Date of Signature:_______________________

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

Physician Signature:____ Date:_________________

**The attending physician's statements regarding disability status are necessary and important for EHP; however, EHP is not bound by the physician's conclusion.