Western Health Advantage

Declaration of Disability For Over Age Dependent Child

This form is required for a dependent child who would normally lose their eligibility under Western Health Advantage solely because of age, but is eligible for disabled status because he/she is chiefly dependent upon the subscriber for support and is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition incurred prior to age 19. This form must be completed and signed by the child's physician and the subscriber and returned to Western Health Advantage no later than _____, 20 _____ or your overage dependent child's healthcare coverage will be cancelled.

Group Name _____ Group No. _____

Subscriber's Name _____

Subscriber Identification Number _____

Dependent Child's Name _____ Date of Birth _____

Dependent Child's Social Security Number _____

This section to be completed by child's physician:

I, the undersigned physician certify that the dependent child name above is incapable of self-sustaining employment because of (specify disability diagnosis): _____

_____

_____

Prognosis: _____

_____

_____

Is this disability permanent? ☐ Yes ☐ No

If no, estimate date of ability for self-sustaining employment _____

_____ _____

Physician's Signature Date

This section to be completed by subscriber:

I, the undersigned parent or guardian certify that the dependent child

_____ _____

Name of Dependent Child Date of Birth

is an unmarried child (including any stepchild or legally adopted child), is chiefly dependent on me for support and is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition.

_____ _____

Parent of Guardian's Signature Date

IMPORTANTE: ¿Puede leer esta carta? Si no, nosotros le podemos ayudar a leerla. Además, usted puede recibir esta carta escrita en español. Para obtener ayuda gratuita, llame ahora mismo al Western Health Advantage (888) 563-2250 lunes a viernes de 8am - 5pm.