

# 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 26.

**This form must be completed and signed by the child's physician and the subscriber and returned to Western Health Advantage no later than (date) \_\_\_\_\_ or the overage dependent child's health care coverage will be cancelled.**

Group Name \_\_\_\_\_ Group # \_\_\_\_\_

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 named above is incapable of self-sustaining employment because of (specific disability diagnosis) \_\_\_\_\_

\_\_\_\_\_

Prognosis \_\_\_\_\_

\_\_\_\_\_

Is this disability permanent?  Yes  No

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

PHYSICIAN NAME (PRINT)

PHYSICIAN SIGNATURE

DATE

**This section to be completed by subscriber:**

I, the undersigned parent or guardian certify that the (name of dependent child) \_\_\_\_\_ born (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 OR GUARDIAN NAME (PRINT)

PARENT OR GUARDIAN SIGNATURE

DATE

**WHA Internal Use Only**

Date Request Received \_\_\_\_\_  Identification Verified (documents checked)

Signature of Manager or Supervisor \_\_\_\_\_

Printed Name \_\_\_\_\_