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 _____