STATE OF WEST VIRGINIA
Public Employees Insurance Agency
Disabled Dependent Eligibility Application

Mail completed form to: PEIA, 601 57th St. SE, Suite 2, Charleston, WV 25304-2345

Part 1 – Policyholder Statement -- To be completed by the Policyholder

Please complete this information for the dependent named below. Complete a separate form for each disabled dependent. The Physician's Statement on page 2 should be completed and submitted along with the other documentation requested in this application. Physician's Statements for a disabled dependent should be submitted only once unless otherwise requested. The completed form along with all requested supporting documentation should be returned to PEIA at the address above for review and final determination of dependent status. **Please print legibly. The information in this form is being requested under provisions of West Virginia Code §5-16-12a(a).**

1. Policyholder's name _____ Social Security Number _____-_____-_____

2. Current address _____ City _____ State ____ Zip _____

3. Dependent Information:

   a. First name _____ MI _____ Last Name_____
   b. Relationship _____ Social Security Number _____
   c. D.O.B.: _____ Gender: ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
   d. If the dependent is married, date of marriage _____
   e. Is dependent covered under any other employer health benefits plan, group health insurance, Medicare, Medicaid, or prepayment of health benefits? ☐ yes ☐ no If you answered yes, please provide a copy of the card or other documentation for that other insurance with this form.
   f. Was dependent covered under this Group Benefits Plan as a dependent on the day preceding the child's 26th birthday? ☐ yes ☐ no
   g. Has the dependent been continuously incapable of self-support due to a disabling sickness or injury since before the child's 26th birthday? ☐ yes ☐ no
   h. Does the listed dependent meet the criteria for a "dependent" as defined by the Internal Revenue Code of the United States? ☐ yes ☐ no
   i. Does the dependent permanently reside in your household? ☐ yes ☐ no
   j. Is the dependent solely supported by you? ☐ yes ☐ no
   k. Has there been a Legal Guardian or Conservator appointed for the Dependent? ☐ yes ☐ no
   l. Are you the legal guardian of or for the dependent? ☐ yes ☐ no If you answered yes, please provide a copy of the complete Court Order granting you Legal Guardianship of the dependent with this form. If you answered no, please provide the name and contact information for the dependent's Legal Guardian: Name: _____ Contact Information: _____
   m. Does the dependent receive income from any other source(s)? ☐ yes ☐ no If yes, how much per month? _____
   n. Has the dependent been awarded Social Security Disability or other disability benefits? ☐ yes ☐ no If yes, please attach a copy of the Social Security Disability Determination Letter or other official documentation with this form.
   o. Please attach any additional information, remarks or documentation, e.g. Power of Attorney forms, etc. that you feel are relevant to this application.

I hereby authorize any person, Guardian, insurance company, organization, employer, hospital, surgeon, physician, dentist, pharmacy, or any other provider of services, to release or disclose to PEIA or its agents any protected health information requested with respect to this statement and its review. I further certify, under penalty of perjury, that the information furnished by me in this form is true and correct to the best of my knowledge. If these circumstances should change in any way, I will inform PEIA immediately.

Policyholder signature _____ Date _____

Dependent signature _____ Date _____

[Physician's Statement on the reverse is to be completed by dependent's physician and returned with this form]

Part 2 — Physician's Statement

Please complete this statement in reference to the dependent named on the reverse side of this form. The policyholder, who is responsible for any fee associated with the completion of this statement, must submit only one such statement unless otherwise requested.

Patient's Name _____Date of Birth _____

History

1. When did the current illness begin, or injury occur? Date _____
2. Was the patient incapable of self-support because of this disabling condition on the day preceding his/her 26th birthday? ☐ yes ☐ no
3. If yes, has the patient been continuously disabled to the present time? ☐ yes ☐ no
4. **Current Condition:** _____
5. Subjective symptoms:

6. Objective findings (Please give date and report of surgery, x-rays, electrocardiogram or any other special tests)
7. Is the patient? Check one ☐ Ambulatory ☐ Bed-confined ☐ House-confined ☐ Hospital-confined
8. Please describe the patient's functional capacity: _____

Diagnosis, Description of Condition or Medical History Causing Disability: (please give as much information as possible.)

_____

_____

Treatment (Please provide dates of first and last visits, and frequency of visits)

1. First visit _____ Last visit _____ Frequency _____
2. Complete list of medications currently used _____

_____

Progress (check one) ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Prognosis (Estimate in months and years) _____

Degree of Disability

1) Has this patient been able to do full or part-time work of any kind? ☐ yes ☐ no
   If yes, since what date? _____
   If not, when do you think the patient will be able to do some work of any kind? _____
2) Is the patient capable of self-support? ☐ yes ☐ no
   If yes, indicate the date the patient became capable of self-support _____

Physician's remarks _____

_____

_____

Name of Physician (please print) _____ Phone ( )_____

Address _____ Suite No. _____

City _____ State _____ Zip Code _____

Physician's Signature _____ Degree _____

Social Security Number or Tax ID _____ Date _____