STATE OF WEST VIRGINIA
PUBLIC EMPLOYEES INSURANCE AGENCY

Disabled Dependent Eligibility Application

PART I -- TO BE COMPLETED BY EMPLOYEE OR PARTICIPANT

Please complete Section I and Section II for the dependent named in Section I. Please complete a separate form for each disabled dependent. The Physician's Statement on the reverse side of this form should be completed and any other medical information submitted along with this application. Physician's Statements for a disabled dependent should be submitted only once each year unless otherwise requested. The completed form should be returned to your employer for review and final determination of dependent status.

SECTION I -- GENERAL INFORMATION

1. Employee or Member's name (Print)_____ Social Security No. _____
2. Present address _____
   Street Apt. no. City State Zip code
3. Dependent's Information:
   (a) First Name _____ Middle Initial ____ Last Name _____
   (b) Relationship _____ Social Security No. _____
   (c) Date of Birth _____ ❑ Male ❑ Female ❑ Single ❑ Married ❑ Widowed ❑ Divorced
   (d) If married, give date of marriage: _____
4. Is dependent covered under any other employer health benefits plan, group health insurance or prepayment of health benefits? ❑ Yes ❑ No

SECTION II -- DISABLED CHILD

1. The Physician's Statement on the reverse side of this form must be completed by the dependent's physician.

2. Was the dependent covered under the Group Benefits Plan as a dependent on the day preceding the child's 19th birthday (25th birthday if full-time college student)? ❑ Yes ❑ No
3. Has the dependent been continuously incapable of self-support because of a disabling sickness or injury since the child's 19th birthday (25th birthday if full-time college student)? ❑ Yes ❑ No
4. Was the dependent covered under the Group Benefits Plan as a full-time student prior to becoming totally disabled? ❑ Yes ❑ No
5. Do you provide more than one half of the dependent child's support as defined by the Internal Revenue Code of the United States? ❑ Yes ❑ No
   If yes,
   (a) Does the dependent permanently reside in your household? ❑ Yes ❑ No
   (b) Is the dependent solely supported by you? ❑ Yes ❑ No
   (c) Are you the legal guardian of the dependent? ❑ Yes ❑ No
6. Is the dependent receiving income from any other source? ❑ Yes ❑ No
   If yes, how much? _____

Employee/Member remarks:

I HEREBY AUTHORIZE ANY INSURANCE COMPANY, ORGANIZATION, EMPLOYER, HOSPITAL, SURGEON, PHYSICIAN, DENTIST OR ANY OTHER PROVIDER OF SERVICES TO RELEASE ANY INFORMATION REQUESTED WITH RESPECT TO THIS STATEMENT.

I CERTIFY, UNDER PENALTY OF PERJURY, THAT THE INFORMATION FURNISHED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. IF THESE CIRCUMSTANCES SHOULD CHANGE IN ANY WAY, I WILL INFORM MY EMPLOYER.

Employee/Member Signature _____ Date _____
Dependent Signature _____ Date _____

TO BE COMPLETED BY PEIA'S MEDICAL EXAMINER

Medical Examiner's Determination: ❑ Disabled ❑ Not Disabled _____
If Not Disabled, Medical Examiner's Opinion:

Medical Examiner's Signature _____ Date _____

(See Reverse Side for Physician's Statement -- to be completed by Dependent's Physician)

Physician's Statement

Please complete this statement in reference to the dependent named on the reverse side of this form. It is necessary for the Employee/ Member, who is responsible for any fee for the completion of this statement, to submit only one such statement each year unless otherwise requested.

1. **Patient's Name** _____ **Date of Birth** _____

2. **History**
   (a) When did present illness begin or injury occur? Date _____
   (b) Was the patient incapable of self-support because of this disabling illness or injury on the day preceding the dependent child's 19th birthday (25th birthday if full-time college student)? _____ ❑ Yes ❑ No

   If yes, has the patient been continuously so disabled to the present time? _____ ❑ Yes ❑ No

3. **Present Condition** _____
   (a) Subjective Symptoms:

   (b) Objective Findings: (Please give date and report of surgery, x-rays, electrocardiogram, or other special tests.)

   (c) Is the patient? (Check one.) ❑ Ambulatory ❑ Bed-confined ❑ House-confined ❑ Hospital-confined
   (d) Please give patient's functional capacity:_____
   _____

4. **Diagnosis, Description of the Condition, or Medical History Causing Disability:** (Give as much information as possible.)

5. **Treatment**: (a) (Give dates of first and last visits and frequency of visits.) First Visit _____
   Last Visit _____
   Frequency _____
   (b) (Complete list of medications currently used:_____
   _____

6. **Progress:** (Check one.) ❑ Recovered ❑ Improved ❑ Unimproved ❑ Retrogressed
7. **Prognosis:** (Estimate in months and years.) _____

8. **Degree of Disability:**
   (a) Has this patient been able to do full or part-time work of any kind?_____ ❑ Yes ❑ No

   If yes, from what date? _____

   (b) If not, when do you think the patient will be able to do some work of any kind? _____
   (c) 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 _____