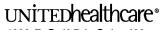
Statement of Dependent Eligibility Beyond Limiting Age In Plan Due to Mental Retardation or Mental or Physical Handicap



1900 E. Golf Rd., Suite 400 Schaumburg, IL 60173

Employee's S	tatement					Answer all		s below. will cause d	alave		
Name (Print)			Last	Last Soci		ocial Security Number		Date of Birth		☐ Male	
Present Address:	Street	City	State	Zip Code	Marital Status:	_/ □ Single □ Marrie			Phone (Inclu Code)	☐ Female uding Area	
Dependent Information											
Name (Print)	First	Middle	Last		Social Sec	urity Numl	er	Date of E	Birth	☐ Male	
Present	Street	City	State	Zip Code	Marital S	_/ Status: □ \$	/ Bingle [Married	Relationshi	□□ Female p to Employee	
Address: Name and address of dependent's current employer											
If not now employed, give date last employed Estimated income from all sources \$			f dependent monthly	supplied by employee			endent	It Is dependent permanently residing in employee's household? ☐ Yes ☐ No If No, Explain ☐			
Is dependent listed as a dependent in your last Federal Personal Income Tax Return?											
Explanations											
I KNOW IT IS A I KNOW ARE II Signed (Emp	MPORTANT.	UT THIS FORM WITH	FACTS I KNOW A	ARE FALSE	OR TO LEAV	/E OUT FAC	ī\$		Date		
Physician's/Surgeon's Statement (Any fee for the completion of this statement is to be paid by the employee.) Answer all questions below. Omitted information will cause delays.											
Patient's Name	First		Middle		Last		-	Patient's Da	te of Birth		
Is this dependent Mental Retarda	Mental Han	mployment by reason of: Mental Handicap? ☐ Yes ☐ No ☐ Yes ☐ No			· c	Date dependent became incapable of self-sustaining employment					
Does the patient have a job? ☐ Yes ☐ No Do you know what the patient's job is? ☐ Yes ☐ No Do you know what duties the patient's job requires? ☐ Yes ☐ No											
Do you know what the patient's job is?											
work of any kind The patient is pre		Yes, From e)	Date	d confined	d 🗆 E	☐ No louse confi		s, From Hospi	tal confined	Date	
Physician's/Surge	ју 🗆 Бе	Address				Phone (Including Area Code)					
i inysician s/ourge						()					
I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT. Date Signed											
Employer's Statement					Answer all questions below. Omitted information will cause delays.						
Employee's Nam	e	First	Mic	ddle		Last			Cert	ificate No.	
Date dependent's	coverage was o	riginally effective	If previously ca	ınceled, g	ive date.						
Employer				Group			Branch		Sub Div	Sub Division	
Signed By				·	Title				Date		
Dependent eligibi	lity will continue	to	For Use By	United H	ealthCare		M	onth	Day	Year	
Dependent eligibility declined. Give reason.											
Signature									Date		