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

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

Employee's Statement

Answer all questions below. Omitted information will cause delays.

Name (Print) First Middle Last	Social Security Number / /	Date of Birth	☐ Male ☐ Female
Present Address: Street City State Zip Code	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Phone (Including Area Code) ( )	

Dependent Information

Name (Print) First Middle Last	Social Security Number / /	Date of Birth	☐ Male ☐ Female
Present Address: Street City State Zip Code	Marital Status: ☐ Single ☐ Married	Relationship to Employee	

Name and address of dependent's current employer

If not now employed, give date last employed	Estimated income of dependent from all sources $_____ monthly	Percentage of support of dependent supplied by employee _____ %	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? ☐ Yes ☐ No If No, Explain

Explanations

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.
Signed (Employee) — 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 Date of Birth
Is this dependent presently incapable of self-sustaining employment by reason of: Mental Retardation? ☐ Yes ☐ No; Physical Handicap? ☐ Yes ☐ No; Mental Handicap? ☐ Yes ☐ No; Other (explain) ☐ Yes ☐ No	Date dependent became incapable of self-sustaining employment.

Diagnosis of condition causing incapacity. If mental retardation is present, give degree of retardation. Give as much detail as possible. Please give date and report of surgery, X-rays, electrocardiograms, or other special tests. Use a separate sheet of paper if necessary.

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
Has this patient been able to do full or part-time work of any kind? ☐ No ☐ Yes, From _____ Date	Will the patient be capable of self support? ☐ No ☐ Yes, From _____ Date

The patient is presently (check one) ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

Physician's/Surgeon's Name (Print) Address	Phone (Including Area Code) ( )

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Signed — Date

Employer's Statement

Answer all questions below. Omitted information will cause delays.

Employee's Name First Middle Last	Certificate No.
Date dependent's coverage was originally effective	If previously canceled, give date.

Employer	Group	Branch	Sub Division
Signed By		Title	Date

For Use By United HealthCare

Dependent eligibility will continue to Month Day Year	
Dependent eligibility declined. Give reason.	
Signature	Date