univera HEALTHCARE

Adult Disabled Dependent Form

Instructions for the Subscriber:

- ☐ Please apply for coverage within 31 days of your disabled dependent aging off your policy
- ☐ Complete Sections 1, 2 and the dependent information above Section 3
- ☐ Sign the bottom of page 2
- ☐ Forward Section 3 to your dependent's doctor
- ☐ Once complete and returned to you, mail the original form to Univera Healthcare P.O. Box 211256, Eagan, MN 55121
- ☐ Send a copy of the form to your employer

The following information is required to determine whether your dependent is eligible for coverage.

Section 1: SUBSCRIBER INFORMATION - Completed by Subscriber			
Last Name:	First Name:		MI:
Street:			
City:		State:	ZIP:
Subscriber ID:	Medical: Dental: Vision:	Phone: ( ) -	

Section 2: DEPENDENT INFORMATION - Completed by Subscriber		
Dependent Last Name:	First Name:	MI:
Does Dependent live with the Subscriber? ☐ Yes ☐ No If no, explain and provide address below:		
Street:		
City:	State:	ZIP:
Date of Birth (MM/DD/YYYY):		
Relationship to Subscriber: ☐ Child (natural or adopted) ☐ Stepchild ☐ Legal Guardianship		
Is Dependent presently married? ☐ Yes ☐ No		

Additional Coverage Information for Dependent:			
Include any other source of coverage for the dependent, including federal, state, local, other commercial health insurance and Medicare.			
Medicare Number (if applicable):	Part A Effective Date	Part B Effective Date	
	/	/	
Medicaid or other governmental coverage if applicable			
Coverage issued through:	ID# (if applicable):	Effective Date	Termination Date
		/	/
Medicaid or other governmental coverage if applicable			
Coverage issued through:	ID# (if applicable):	Effective Date	Termination Date
		/	/
		/	/

I request coverage under my policy for my adult disabled dependent named on this form. I understand that their enrollment may be continued only as long as they are:

- Unmarried
- Incapable of self-sustaining employment by reason of: mental illness, developmental disability, intellectual disability, cerebral palsy, Down Syndrome, autism spectrum disorders, neurological impairments or physical handicap
- Financially dependent on me for 50% or more of their support, and
- Continuously covered under my policy after the date they would otherwise age off the policy.

I also understand that:

- I'll inform Univera Healthcare of any changes in the status of my dependent's disability or eligibility for coverage (for example, marriage) and that
- Univera Healthcare has the right to require periodic recertification of my dependent's ongoing eligibility for coverage as a disabled dependent.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Subscriber Signature:	Date:

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Dependent Information (subscriber, please repeat information from page 1):		
Last Name:	First Name:	MI:
Street:		
Date of Birth (MM/DD/YYYY):		Sex:

Instructions for the Physician:

This form is to determine whether your patient is eligible for coverage beyond the date that they will otherwise age off the policy. Thank you in advance for your prompt and thorough attention to this form on behalf of your patient as it is a critical for the determination.

- ☐ Complete and sign Section 3
- ☐ Attach any applicable documentation to support status (i.e. clinical summary)
- ☐ Return the original to the subscriber

Section 3: MEDICAL INFORMATION - COMPLETED BY ATTENDING PROVIDER (MD, DO, NP or PA):
1. Diagnosis (Please use standard nomenclature):
2. If physically disabled, was this the result of an accident? ☐ Yes ☐ No
3. If mental illness*, describe limitations:
If 2 or 3, describe treatment and rehabilitation currently received by patient:
Has there been IQ or other testing? ☐ Yes ☐ No If yes, please submit summary with this form.
*Please attach a copy of patient's last psychological evaluation, WAIS and/or MMPI report

Is your patient able to:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Feed Self	☐	☐	Dress Self	☐	☐	Bathe Self	☐	☐	Toilet Self
☐	☐	Read	☐	☐	Write	☐	☐	Speak	☐	☐	Handle Money
☐	☐	Drive Vehicle	☐	☐	Ambulate Independently	☐	☐	Transfer Self, bed to chair	☐	☐	Use Public Transportation

To your knowledge, the length of time this disability has existed:
Congenital or Date of Onset:

Probable future course and duration: _____

_____

_____

Does patient currently reside in a group home or health care facility? ☐ Yes ☐ No

If yes, provide name of facility:

In your professional opinion, can this patient currently engage in self-supporting employment?
☐ Yes ☐ No

In what timeframe do you expect your patient to be self-sufficient?

_____

Please elaborate on the reason(s) for your answer: _____

_____

_____

I certify that this patient is presently under my care and that I see this patient on a regular ongoing basis.

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Physician Signature:	Date:
Name of Physician (please print):	Phone: ( )
Physician's Address:	

Office Use Only:			
☐ Not Approved	Date:	Reviewer:	
	Reason:		
☐ Approved	Date:	Reviewer:	
	Effective Date:	Medical Recertification Date:	
	Reason		
	Eligibility Recertification Date:		
	Processed By:		Date: