

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



Employee's Statement					Answer all questions below. Omitted information will cause delays.			
Name (Print)	First	Middle	Last	Social Security Number	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Present Address:	Street	City	State	Zip Code	Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Phone (Including Area Code) ()

Dependent Information								
Name (Print)	First	Middle	Last	Social Security Number	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Present Address:	Street	City	State	Zip Code	Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Explain			
Is dependent listed as a dependent in your last Federal Personal Income Tax Return?					<input type="checkbox"/> Yes <input type="checkbox"/> No If No, Explain			
Explanations								
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.								Date
Signed (Employee)								

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? Physical Handicap? Mental Handicap? Other (explain) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Do you know what the patient's job is? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you know what duties the patient's job requires? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Has this patient been able to do full or part-time work of any kind? <input type="checkbox"/> No <input type="checkbox"/> Yes, From _____ Date		Will the patient be capable of self support? <input type="checkbox"/> No <input type="checkbox"/> Yes, From _____ Date						
The patient is presently (check one) <input type="checkbox"/> Ambulatory <input type="checkbox"/> Bed confined <input type="checkbox"/> House confined <input type="checkbox"/> Hospital confined								
Physician's/Surgeon's Name (Print)			Address	Phone (Including Area Code) ()				
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.				Date				
Signed								

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 Metropolitan

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