UnitedHealthcare
A UnitedHealth Group Company

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

Statement of Dependent Eligibility Beyond Limiting Age Due to Mental or Physical Disability

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) ( )

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

Date

For Use By United HealthCare

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