June 14, 2016

Disabled Dependent Continuation of Dental and/or Vision Benefit Request

TO BE COMPLETED BY PLACER COUNTY EMPLOYEE

For a child to be eligible as a disabled dependent, the following must be true:

- The child is unmarried
- The child is incapable of self-support because of a mental or physical condition
- The child is over the age of 23
- The disability existed prior to reaching age 23 and continuously since age 23, as certified by a licensed physician.

PART A: The employee is to complete the information in Part A

Name of employee: _____

Dependent child name : _____

Social Security Number: _____ Date of Birth: _____

Address: _____

_____

_____

1. Is the dependent economically dependent upon you for his or her support? ☐ Yes ☐ No
2. I claim the child as my dependent for income tax purposes ☐ Yes ☐ No
3. Is the dependent working? ☐ Yes ☐ No
4. Is the dependent incapable of self-support because of a physical or mental disability? ☐ Yes ☐ No

   If yes, what age did the dependent become physical or mentally disabled? _____
5. Does the dependent have access to other insurance coverage for dental and/or vision? ☐ Yes ☐ No

   -If yes please provide a brief description: _____

x _____ x _____

Employee signature Print employee name

Part B: Dependent Authorization: The dependent, or person authorized to act in his or her behalf, is to complete the information requested in PART B prior to giving the form to the physician for completion.

I hereby authorize my attending physician, _____ , to furnish and disclose all facts concerning my disability that are within his or her knowledge concerning my disability. This authorization shall be valid for a period of one year from the date of my signature or the effective date of this claim, whichever is later. I agree that a photo copy of this authorization shall be as valid as an original. I understand that if I do not sign this authorization, or if I revoke or modify it, Placer County Human Resources Department may not be able to determine my eligibility as a disabled dependent and that my request may be denied. I also understand that Placer County Human Resources Department will keep confidential the information which is provided pursuant to this authorization and that it will be used solely to determine and act upon my request for this benefit.

x _____ x _____

Signature of Dependent OR Date signed

x _____ x _____

Person authorized to act on his/her behalf Relationship to the Dependent

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TO BE COMPLETED BY HEALTH CARE PROVIDER

PART C: Medical Certification of Disability and Incapacity of Self-Support: For purposes of this benefit, a disabled dependent of a Placer County Employee can retain his or her eligibility for Dental and Vision benefits as a family member if he or she is unmarried and incapable of self-support (i.e. not capable of engaging in any substantial gainful activity) due to a physical or mental disability which existed continuously prior to reaching 23 years of age.

***Please do NOT send documents, copied or otherwise from patient's medical record.**

1. Based upon your examination, does the patient currently have a physically or mentally disabling injury, illness or condition?
   - ☐ NO, the patient does NOT have a physically or mentally disabling injury, illness or condition.
   - ☐ YES

2. In your opinion, please select **A**, **B** or **C**.
   - ☐ **A:** The patient's current disability DOES NOT render him or her incapable of self-support.
   - ☐ **B:** The patient's current disability DOES render him or her incapable of self-support, but the disability should resolve or improve sufficiently for the patient to be capable of self-support by _____.
     PROJECTED DATE (mm/yy)

     If the condition is likely to improve or resolve, make SOME estimate of when this will occur. Please DO NOT leave the PROJECTED DATE blank. Answers such as "indefinite" or "don't know" will not suffice.

   - ☐ C: The patient's current disability is of a permanent or extended duration and, consequently, the patient is not and will not be capable of self-support within the foreseeable future (e.g., more than 5years).

I certify that, based upon my examination of the patient, the above statements truly describe the patient's disability and his or her capability of self-support, and that I am a _____ (Type of Physician), _____ (Specialty, if any)

Licensed to practice by the State of _____.

X _____ X _____

Signature of Physician | Print name of Physician as shown on license

Physician Address _____ State License Number: _____

City, State, Zip _____ Telephone Number: _____

Date: _____ Fax Number: _____

Return this form to: Placer County Human Resources
145 Fulweiler Avenue, Suite 200 Auburn, CA 95603

You may confidentially fax this form to: Placer County Human Resources (530) 889-4078