Special Needs Dependent Over Age 26
Disability Waiver

Date: _____

Dependent: _____

Date of Birth: _____

Parent or Guardian: _____

Medicare Number: _____

Medicaid Number: _____

An application for group health benefits from Independent Health/Nova Healthcare OR MVP Health Care has been filed for _____, and we require medical information from the primary care physician in order to determine eligibility under the subscriber's group health contract. We would therefore appreciate receiving the information requested on the attached form to assist us with this process.

Thank you for your assistance.

DEPENDENT DISABILITY WAIVER GENERAL MEDICAL REPORT

(This form must be completed by your Primary Care Physician)

Dependent's Name: _____

Date of Birth: _____

Member Number: _____

Date member became disabled: _____

1. Dates of Treatment: first _____ last _____ frequency _____

2. Diagnosis: _____

3. History and subsequent course including data of onset, earliest symptoms, etiology of impairment, initial findings on physical examination, treatment (including surgical procedures), and medications:

4. Date of LAST examination:

5. Findings on LAST examination (including vital signs, pertinent physical findings):

6. Describe how the activities of daily living are affected by this impairment:

7. Please provide treatment plan, response and date of expected improvement:

8. Employment History:

9. Based on your assessment, do you consider the above named patient incapable of sustaining employment due to mental illness, mental retardation or physical handicap?

YES / NO / UNABLE TO MAKE THIS DETERMINATION

Physician's Signature: _____

Address: _____

Telephone Number: _____

NY44 Health Benefits Plan Trust

Affidavit of Eligibility for Dependents over Age 26

I, hereby affirm that is incapable of self-sustaining employment because of mental illness, mental retardation, developmental disability or physical handicap, and is dependent upon me for support and maintenance. Attached to this affidavit are the first page of the immediate past year's Federal income tax return, dependent must be listed, and a statement from primary care physician.

I understand that any false statement on this affidavit will result in a loss of coverage for, retroactive to the first day of the current plan year.

_____ _____

Signature Date

Federal income tax return: (Tax Year) _____

Acknowledgment of Individual

STATE OF NEW YORK

COUNTY OF _____

On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Notary Public

Printed Name: _____ My Commission Expires: _____

Office Use Only:

Initial _____ Update: _____