Determination as Disabled Dependent Request
Psychological or Physical Disability

AmeriBen

PURDUE UNIVERSITY

AmeriBen, Attn: Client Services | PO Box 7186 | Boise, ID 83707 | Fax: 208-955-1415

Instructions:

1. Please type or print clearly.
2. Complete only the section entitled "To Be Completed by the Employee." The reverse side is to be completed by the dependent's attending physician or psychologist.
3. Enter your name and identification number as they appear on your identification card.
4. After completing the employee portion of this form, please give this form to the physician or psychologist who has firsthand knowledge of the dependent's condition.
5. Ask the physician or psychologist to complete and personally sign the reverse side of this form and then return the form to AmeriBen by mail or fax.
6. If the dependent is not presently covered under your Plan, documentation from the dependent's current or previous insurance company verifying Disabled Dependent Status since before age 26 and indicating termination date is required.

Section I — To Be Completed by the Employee

Employee name:_____Group ID_____ID No:_____

Employee Address_____ Type of Coverage: ☐ Individual ☐ Family
Street no. and Name

_____ Telephone No: _____-_____-_____
City, State, Zip

Dependent name _____ Dependent Date of Birth_____/_____/_____

Dependent address_____ Dependent Marital Status ☐ Single ☐ Married
Street no. and Name

_____
City, State, Zip

When was the onset of the disability? ☐Birth ☐ Other (indicate approximate date):_____/_____/_____

Is the dependent confined to an institution or attending school? ☐ Yes ☐ No If yes, Indicate date of admission:___/___/____

Name and address of institution or school:_____

Is the dependent employed for wages? ☐ Yes ☐ No If yes, indicate date of employment_____/_____/____ Hours worked per week:_____

Name and address of dependent's employer:_____

Is the dependent covered by the federal Medicare Health Insurance Program ☐ Yes ☐ No Medicare category: ☐ Disabled ☐ Kidney Disease

If yes, please provide Medicare Health Insurance Claim number:_____

Hospital Insurance (Part A) effective date:_____/_____/_____ Medical Insurance (Part B) effective date:_____/_____/_____

Is dependent covered under Medicaid? ☐ Yes ☐ No

Is the dependent covered by any other insurance? ☐ Yes ☐ No If yes, please provide the following information:

Name if Insurance Company:_____ Policy Holder's Name:_____

Insurance Company Address:_____

I attest the to the best of my knowledge and belief the information given above is correct. I understand that coverage under my Employer's Group Benefit Plan (the"Plan") may remain in force only as long as the dependent continues to meet the definition of disabled dependent child under my Plan and while my coverage level includes such dependents. I further understand that the Plan shall have the right to require confirmation of continued eligibility for this dependent from time to time as often as the Plan may deem reasonable. I authorize any doctor, health care provider, hospital, clinic, or other medically related facility who has knowledge of the dependent to provide AmeriBen with any information that will aid in the determination of the dependent's status as a disabled dependent.

Signature of Employee:_____Date: _____/_____/_____

If you have questions about completing this form, please call AmeriBen at 833-782-9474

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Section II To Be Completed by the Dependent's Attending Physician

Patient Name:_____ Patient Date of birth: ____/____/_____

Patient's height: _____Ft._____In. Patient's weight_____lbs.

Diagnosis:_____
Please print or type

_____

Severity : ☐ Mild ☐ Moderate ☐ Severe

To your knowledge, how long has this disability existed: ☐ Since birth ☐ Other (indicate date of onset):____/____/_____

Is the patient presently under treatment? ☐ Yes ☐ No

If yes, please describe the nature of the treatment:_____
Please print or type

_____

Please describe the disability at the time of the patient's 19th birthday:

Physical disability:_____

_____

Psychological Disability:_____

_____

If the patient is intellectually disabled, what is the mental age or I.Q.? MA:_____ I.Q.:_____

Prognosis: _____
Please print or type

Is the condition likely to improve?_____

Probable future course of treatment and duration:_____
Please print or type

_____

In your professional opinion, is the patient capable of engaging in substantial gainful employment or schooling for employment? ☐ Yes ☐ No

If patient is employed, do you know what duties the patient's job requires? ☐ Yes ☐ No If yes, please describe duties:_____

_____

In your professional opinion, will this patient ever be capable of substantial gainful employment? ☐ Yes ☐ No If yes, when:____/____/_____

Remarks:_____
Please print or type

_____

Signature of physician or psychologist:_____ Date:_____/_____/_____

Please Print the Following Information

Full Name of Physician or Psychologist:_____ Tel. no:_____

Office Address:_____

If you have questions about completing this form, please call AmeriBen at 833-782-9474

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 7186 Boise, ID 83707, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf