

## STATE OF WEST VIRGINIA Public Employees Insurance Agency Disabled Dependent Eligibility Application

Mail completed form to: PEIA, 601 57th St. SE, Suite 2, Charleston, WV 25304-2345

## Part 1 – Policyholder Statement -- To be completed by the Policyholder

Please complete this information for the dependent named below. Complete a separate form for each disabled dependent. The Physician's Statement on page 2 should be completed and submitted along with the other documentation requested in this application. Physician's Statements for a disabled dependent should be submitted only once unless otherwise requested. The completed form along with all requested supporting documentation should be returned to PEIA at the address above for review and final determination of dependent status. **Please print legibly. The information in this form is being requested under provisions of West Virginia Code §5-16-12a(a).** 

1. Policyholder's name			Social Security Number					
2. Current address			City		St	State Zip		
3. Depe	ndent Information:							
a.	First name	MI	l	Last Name				
b.	Relationship	Sc	ocial Security	Number				
с.	D.O.B.: Gende	: 🗆 Male	Female	Status: 🛛 Single	□ Married	□ Widowed	Divorced	
d.	If the dependent is married, date of married	iage				. <u></u>		
e.	Is dependent covered under any other	employer	health bene	fits plan, group he	alth insuranc	e, Medicare,	Medicaid, or	
	prepayment of health benefits?	s □ no	If you	answered yes, ple	ase provide a	a copy of the	card or other	
	documentation for that other insurance							
f.	Was dependent covered under this Grou	p Benefits P	Plan as a dep	endent on the day p	preceding the	child's 26 <sup>th</sup> bi	rthday?	
	yes no							
g.	Has the dependent been continuously in		self-support	due to a disabling s	ickness or inj	ury since befo	re the child's	
h	26 <sup>th</sup> birthday?  yes no		un availa unt" au					
h.	Does the listed dependent meet the crite	ria for a de	ependent as	defined by the inte	rnai Revenue	Code of the U	nited States?	
i.	Does the dependent permanently reside	in your hou	isehold? [	lves 🗆 no				
j.	Is the dependent solely supported by you	-						
j. k.	Has there been a Legal Guardian or Cons	•		e Dependent?	🗆 ves	🗆 no		
I.	Are you the legal guardian of or for the d						a copy of the	
	complete Court Order granting you Lega	•	•	•		•	• •	
	the name and contact information for t				-	-	-	
	Information:							
m.	Does the dependent receive income fr	om any oth	ner source(s	)? □ yes □	no Ifye	s, how much	per month?	
	-	-						

- n. Has the dependent been awarded Social Security Disability or other disability benefits? attach a copy of the Social Security Disability Determination Letter or other official documentation with this form.
- o. Please attach any additional information, remarks or documentation, e.g. Power of Attorney forms, etc. that you feel are relevant to this application.

I hereby authorize any person, Guardian, insurance company, organization, employer, hospital, surgeon, physician, dentist, pharmacy, or any other provider of services, to release or disclose to PEIA or its agents any protected health information requested with respect to this statement and its review. I further certify, under penalty of perjury, that the information furnished by me in this form is true and correct to the best of my knowledge. If these circumstances should change in any way, I will inform PEIA immediately.

Policyholder signature	Date
Dependent signature	Date

[Physician's Statement on the reverse is to be completed by dependent's physician and returned with this form]

## Part 2 — Physician's Statement

Please complete this statement in reference to the dependent named on the reverse side of this form. The policyholder, who is responsible for any fee associated with the completion of this statement, must submit only one such statement unless otherwise requested.

Patient's	Name			Date of Birth		
History						
1.	When did the current illness begin, or injury occur?	Date				
2.	Was the patient incapable of self-support because of no				<sup>th</sup> birthday? 🛛 yes	
3.	If yes, has the patient been continuously disabled to t	the present time?	□ yes	🗆 no		
4.	Current Condition:					
5.	Subjective symptoms:					
6.	Objective findings (Please give date and report of sur	gery, x-rays, electrocar	diogram or a	iny other special tests	;)	
7.	Is the patient? Check one Ambulatory Bed-					
8.	Please describe the patient's functional capacity:					
Diagnosi	s, Description of Condition or Medical History Causing	g Disability: (please gi	ve as much i	nformation as possib	le.)	
Treatme	nt (Please provide dates of first and last visits, and fre					
1.	First visit Last visit		Freq	uency		
2.	Complete list of medications currently used					
Progress	(check one)	nanged	sed			
Prognosi	s (Estimate in months and years)					
Degree o	of Disability					
1) H	las this patient been able to do full or part-time work o If yes, since what date?	of any kind? 🛛 yes	🗆 no			
	If not, when do you think the patient will be able to d		nd?			
2) Is	s the patient capable of self-support?					
<b>D</b> I						
Physician	n's remarks					
Name of	Physician (please print)			Phone (	)	
	· · · · · · · · · · · · · · · · · · ·					
	n's Signature			Degree		
	curity Number or Tax ID			Date		