DISABLED DEPENDENT CERTIFICATION

PLEASE READ CAREFULLY

The "Disabled Dependent Certification" form is used to determine if your adult dependent child meets the plan's eligibility requirements for continued coverage after the age limit is reached.

IMPORTANT NOTE

The inability to find employment or a reduction in work force is, of themselves, NOT evidence of eligibility for continuation of coverage.

INSTRUCTIONS

You or your physician may submit the information requested in this "Disabled Dependent Certification" form. Please complete all required sections and sign the attestation statement at the end. ManhattanLife must receive the completed paperwork within 31 days of the dependent turning 26.

Step 1: Complete all applicable sections of the Disabled Dependent Certification form.

Step 2: Subscriber must complete and sign the applicable fields.

Step 3: Licensed physician must complete and sign the applicable fields. (where applicable)

Step 4: Include *one* of the following information:

- Copy of the Social Security Disability Insurance* (SSDI) Award Letter (where applicable)
- Copy of the active Court Order (where applicable) example: Legal Guardianship
    - *If copy of SSDI OR Court Order are not available; the Physician's attestation must be completed, and signature required*
- Physician Attestation (where applicable)

Step 5: Send to:

ManhattanLife
PO Box 926169
Houston TX 77292

If you have any questions regarding the attached form please contact Customer Service at 855-448-6982

CONDITIONS OF ELIGIBILITY

Under the provisions of the Contract coverage, a dependent who is mentally or physically disabled may continue coverage to any age provided:

1. Dependent became disabled before reaching the limiting age (over the age of 25).
2. Dependent must be incapacitated or incapable of self-sustaining employment.
3. Dependent must be mentally or physically disabled prior to attainment of the age where coverage would otherwise be terminated.

Social Security Disability Insurance is the Federal Insurance Program

Supplemental Security Income (SSI) program pays benefits to disabled adults and children who have limited income and resources.

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ALL SECTIONS MUST BE COMPLETED PER INSTRUCTIONS (review carefully)

SECTION 1: SUBSCRIBER INFORMATION				
Full name of Subscriber: (last, first, middle)	Subscriber ID#:		Group #:	
Street Address:	City:	State:	Zip code:	Telephone No:

SECTION 2: DEPENDENT INFORMATION			
Full Name of disabled dependent: (last, first, middle)	Date of birth:	Relationship to Subscriber:	
Marital Status: ☐ Married ☐ Single	Address: (if different than subscriber)		
Sex: ☐ Male ☐ Female	Nature of disability:		Date of disability:

SOCIAL SECURITY DISABILITY OR LEGAL GUARDIANSHIP SUPPORTING DOCUMENTS		
Has the dependent been declared disabled by the Social Security Administration? ☐ If Yes, (attach SSDI and/or SSI document) ☐ If No, provide subscriber signature below and then continue to section 3 If yes, complete the following: • Copy of the SSDI* Award letter and/or • Applicable court order • Sign on the Subscriber signature line and STOP If no, provide subscriber signature and then continue to section 3. Subscriber Signature: _____	OR	Has the dependent been placed in Legal Guardianship by a court order? ☐ If Yes, (attach active court order) ☐ If No, provide subscriber signature below and then continue to section 3 If yes, complete the following: • Attach the copy of the active Legal Guardianship court order • Sign on the Subscriber signature line and STOP If no, provide subscriber signature below and then continue to section 3. Subscriber Signature: _____

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SUBSCRIBER SIGNATURE – must be signed for the form to be valid

Please note: it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I certify/attest that <Dependent's Name> meets the following criteria:

1. The dependent became disabled before reaching the limiting age; and
2. Is incapable of self-sustaining employment due to disability; and
3. The dependent relies primarily upon Subscriber (and/or spouse) for support and maintenance.

Subscriber's Signature _____

Date of Signature _____

(My signature attests that the above statements are true and if requested I can provide further substantiating documentation.)

SECTION 3: PHYSICIAN'S INFORMATION – the following must be completed, signed and certified by a physician.

IMPORTANT NOTE
The inability to find employment or a reduction in work force is, of themselves, NOT evidence of eligibility for continuation of coverage.

Provider Name:	Provider Mailing Address:	Provider Contact Phone: Fax Number:
Date of Patient's last exam: (The application date and date of the last exam must be Must be within the past year)	Disability is Complete 100% ☐ Yes ☐ No	Disability is: Partial ____%
Is this disability temporary or permanent? ☐ Temporary ☐ Permanent		If temporary, estimated duration:
Diagnosis causing disability: (provide ICD-10 and standard nomenclature of condition)		
Will dependent/patient be capable of self-support ☐ Yes ☐ No. If yes, when (date)		

Please note: it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signature of Attending Physician (Print / Credentials): _____

Date of Signature: _____

(My signature attests that the above statements are true and if requested I can provide further substantiating documentation.)