UMR
PO BOX 30541
Salt Lake City UT 84130-0541

Employee:
ID# :
RE :
Employer :

Information received indicates that the dependent named above is age 26 years or over and may be eligible to continue enrollment under the plan as a disabled adult dependent.

If your dependent is currently receiving Supplemental Security Income (SSI) please submit this documentation as well as page one of the enclosed Statement of Dependent Eligibility Beyond Limiting Age In Plan Due to Mental or Physical Disability form. If your dependent is not receiving SSI, please work with your dependent's treating physician to complete and return the attached form in its entirety. All documentation must be received within 30 days from the date of this letter.

Please return via fax, 877-293-4914 or mail to Enrollment Services at the mailbox below:

Enrollment Services
PO BOX 8052
WAUSAU, WI 54402

Failure to provide the requested information will result in termination of coverage for this dependent.

Please contact us at 800-826-9781 if you have any questions.

Enrollment Services
444

Statement of Dependent Eligibility Beyond Limiting Age In Plan Due to Mental or Physical Disability

...Questions should be directed to the Customer Service number located on the back of your **ID** card..

Employee's Statement

Employee to complete Sections I, II, & III. **Omitted information will cause delays.**

Section I. Employee Information

PRINT Name: (First, Middle, Last)				Gender (Circle One) Male Female
Date of Birth / /	Member ID	Relationship to Dependent:	Marital Status: (Circle One) Single Married Divorced Widowed	Phone: (Including Area Code) ( )

Current Address(es) (Street, City, State, Zip Code)

Physical:

Mailing:

Email:

Section II. Dependent Information

(**Refer to your Member Handbook for who qualifies as an eligible dependent.**)

PRINT Name: (First, Middle, Last)			Gender (Circle One) Male Female
Date of Birth / /	Marital Status: (Circle One) Single Married	Circle **all applicable** orders in place by Employee regarding Dependent. If circled, submit a copy of each with application. Conservatorship Guardianship Court Order Divorce Decree	

Currently Resides at: (Street, City, State, Zip Code)

Physical:

Mailing:

Does the Dependent reside in your household? (Circle one) **YES/ NO**

If **NO,** provide reason for different residing address than employee below. (Example: Lives in a group home, medical facility, etc.)

Section III. Financial and Dependent Employment Information

1. **For New Employees, was dependent covered under your prior Employer's Insurance Plan?** (Circle One) **YES** / **NO** / **Not Applicable**

1a. If YES, provide coverage dates. From: __ __ / __ __ / __ __ To: __ / __ __ / __ __

1b. If NO, please explain.

2. Does employee provide more than 50% of the dependent's support and maintenance (food, meds, utility, housing, etc.)? (Circle One) YES / **NO**

3. Was dependent listed as a dependent on your last Federal Personal Income Tax Return? {Circle One) **YES** / **NO**

3a. If above is NO, provide explanation below.

4. **Does** dependent **receive SSDI/SSI** benefits? {Circle one) **YES** / **NO**	4a If YES, Amount per Month $ {Submit current copy)

5. Is dependent currently working? {Circle One) Full Time Part Time Currently Not Working Date Last Employed

Sa. If dependent is currently working, Gross Monthly Income (before taxes)$

Sb. Does dependent's current employer offer health insurance? {Circle One) **YES** / **NO**

Sc. Provide Name and address of dependent's current employer below: (Street, City, State, Zip Code)

6. Explanations/Additional Information: (attach additional pages if needed)

I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH INFORMATION I KNOW IS FALSE OR TO LEAVE OUT INFORMATION I KNOW IS IMPORTANT.

▶ Employee Signature: Date: / /

For processing purposes, pages 1 and 2 MUST be submitted together.

Statement of Dependent Eligibility Beyond Limiting Age In Plan Due to Mental or Physical Disability

...Questions should be directed to the Customer Service number located on the back of your ID card..

Medical Provider Statement

{Any fee for the completion of this statement is to be paid by the employee.)
Answer all questions below. Omitted information will cause delays.

Patient's Name: (First, Middle, Last)	Patient's Date of **Birth** / /

1. What is the primary disabling diagnosis?

2. From what Age has such disability existed continuously? (Circle One) From Birth From_ Years of Age

3. The patient is presently: (Circle all applicable) Ambulatory Confined To: Bed House Hospital Wheelchair

4. What are the physical/mental/functional limitations related to the primary disabling diagnosis?

5. Are there any other diagnoses currently being treated? (Circle One) YES / NO | Sa. If YES, please list:

6. Is patient currently able to work? (Circle One) YES / NO | 6a. If YES, (Circle One) Full Time Part Time

7. Is patient currently able to be self-supportive? (Circle One) YES / **NO**

8. If you answered NO to either Question 6 or 7 above. Please explain below.

(circle all applicable) Intellectual/Developmental Disability Physical Handicap Mental Handicap Other (Explain below)

9. Will patient be capable of self-support in the future? (Circle One) YES / NO | 9a. If **YES,** As of What Date: / /

Please attach any current (within the last three (3) months) written documentation or medical records.

PRINT Medical Provider Name, Address (Street, City, State, Zip Code)	Phone: (Including Area Code) ( )

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▶ Medical Provider Signature: Date: / /

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