

DISABLED DEPENDENT APPLICATION

Please note that in order for a dependent to apply for disabled dependent coverage, they must meet one of the following conditions:

- Became mentally or physically incapable of earning their own living prior to age 19; or
- Became permanently and totally disabled and became so on or after age 19 and is under age
 26. These dependents will only be covered until the last day of the month they turn 26.

If your dependent meets one of these two requirements, we have listed below information for you to return to the GIC so that a decision can be made on your application. If your dependent is working, please include a copy of their latest earnings statement.

INFORMATION FROM THE INSURED PARENT

The insured parent must complete the "Statement From Insured Parent For Disabled Dependent Coverage" (page 1 of 2). Please answer all questions completely so that we can process your application as quickly as possible.

INFORMATION FROM THE DEPENDENT'S PERSONAL PHYSICIAN

Please have the Physician's Statement (page 2 of 2) completed by the dependent's personal physician; the physician must be licensed to practice medicine in Massachusetts or the state in which you reside.

Please return the entire completed application to us. You can expect to have a response within four to six weeks of the GIC receiving your completed application. If you have any questions you can contact us at (617) 727-2310.

STATEMENT FROM INSURED PARENT FOR DISABLED DEPENDENT COVERAGE

Please complete all questions. Incomplete forms will be returned.

Dependent's Date of Birth			
בסףטוומטווגט במנטטו בווווו	Dep	endent's Soc. S	ec. Number
Dependent's Address			
City			
Dependent's Marital Status			
Full Name of Insured			
Insured email address			
Insured Phone Number			
Insured's Address			
City		State	Zip
Insured's Social Security Number			
Date Dependent Became Totally Disable			<u></u>
Is your dependent working? Yes	No		
Is yes, indicate name of employe	r		
Indicate annual salary			
If the dependent is over age 19, have the	ey had healt	h insurance cov	verage from age 19 to the present
YES No			
If YES, please provide the following:			
Name of Insurance Carrier			
Name of Employer			
The effective date of coverage			
Is coverage still in effect? Yes No			
Is coverage still in effect? Yes No. If No, when was coverage cancelled and If No, please provide the following:			
If No, when was coverage cancelled and	d why?		
If No, when was coverage cancelled and If No, please provide the following:	d why? Benefits? Yes	No	
If No, when was coverage cancelled and If No, please provide the following: Is your dependent eligible for Medicare B	d why? Benefits? Yes ne Medicare	s No Claim Card	Never Applied for Medicare
If No, when was coverage cancelled and If No, please provide the following: Is your dependent eligible for Medicare B If YES, please include a photocopy of the	d why? Benefits? Yes be Medicare Jocal Social S	s No Claim Card	Never Applied for Medicare
If No, when was coverage cancelled and If No, please provide the following: Is your dependent eligible for Medicare B If YES, please include a photocopy of the If NO, please include a letter from your I	d why? Benefits? Yes be Medicare local Social S enefits.	S No Claim Card Security Office a	Never Applied for Medicare
If No, when was coverage cancelled and If No, please provide the following: Is your dependent eligible for Medicare B If YES, please include a photocopy of the If NO, please include a letter from your I dependent is not eligible for Medicare be Please read and sign the following states.	Benefits? Yes be Medicare local Social Senefits. The ment and if the coverage and the cove	No Claim Card Security Office a se dependent is agree to period tify under the pa erstand that if I in	Never Applied for Medicareadvising of the reason the capable, please also have the dic independent physician ains and penalties of perjury that a misrepresent or provide false or inated (possibly retroactively), in
If No, when was coverage cancelled and If No, please provide the following: Is your dependent eligible for Medicare B If YES, please include a photocopy of the If NO, please include a letter from your I dependent is not eligible for Medicare be Please read and sign the following statent dependent sign. I hereby apply for disabled dependent of examinations as requested by the GIC. statements I have made on this form, my	d why?	No Claim Card Security Office a see dependent is agree to period tify under the pa erstand that if I in age may be term quences, at the	Never Applied for Medicareadvising of the reason the capable, please also have the dic independent physician ains and penalties of perjury that a misrepresent or provide false or inated (possibly retroactively), in

Page 1 of 2 4/23

PHYSICIAN'S STATEMENT FROM ATTENDING PHYSICIAN

Please complete all questions. Incomplete forms will be returned.

Insured Parent's Name————————————————————————————————————
Name of Patient —
Patient's diagnosis and date of illness
(a) Is the patient currently working? YES——— NO———
(b) Is the patient currently capable of self support YES — NO — N
(c) If NO to question b is there any potential that the patient will eventually be capable of self-support? YES NO
(d) If YES to question c, please provide your best estimate of when the patient will be capable of self-
support. ————————————————————————————————————
Date of onset of disability (the inability to support themselves).
How long have you been treating this patient for the diagnosis indicated above? State other diagnosis if
necessary.
Include first and most recent visits.
Describe your treatment plan including a prognosis and goals for this patient in as much detail as possible and, if the patient is enrolled in a vocational training, rehabilitation or similar program, include goals and timetables that have been established for the program. (Attach other sheets as necessary.)
Under the pains and penalties of perjury, I attest that all statements I have made on this form are true.
Physician's Signature Date
Physician's Data (please print or type the following information):
NameSpecialty
Address City State Zip Code
Telephone No

Commonwealth of Massachusetts Group Insurance Commission P.O. Box 556 Randolph, MA 02368

Insured: Mail pages 1 and 2 together to the GIC at the address below. Keep a copy for your records.

Page 2 of 2 4/23