Disabled Dependent Procedures

PLEASE READ CAREFULLY

Enclosed is the application necessary to file a request disabled dependent coverage if you have a dependent child who is disabled and is over age 26.

To continue coverage under the EIT Health & Welfare Plan, the Plan states , in pertinent part, under Section 4.06 of the Plan states,

"The Child must have been diagnosed with a severe physical or mental disability and the disability is expected to last for a continuous period of 12 or more months or more, provided:

- Such incapacity began before the end of the month the Child attains age 19; and
- The Child was covered by the Plan on the day prior to his or her 19th birthday; and
- The Child is dependent on you for more than 50% of his or her financial support and maintenance for the calendar year; and
- The Child resides in your home; and
- The Child's disability is not solely due to alcoholism or drug addiction; and
- You (the Participant) remain eligible for coverage under the Plan.

A completed application consists of the following:

- **Disabled Dependent Coverage Application**
  - Section 1: Must be completed by you
  - Section 2: Must be completed by your child's attending physician
- **Disabled Dependent Affidavit** *(must be notarized by a Notary Public)*
- **Copy of most current insurance or Medicare Card** *(if covered by another group plan or Medicare)*

If approved, we will periodically request documentation to support your dependent's continued condition(s) that prevents them from supporting themselves, this may include a detailed statement from your dependent's physician outlining the nature of the medical condition(s) that incapacitates your child.

Additionally, the attached Disabled Dependent Affidavit attesting that your child is not capable of self-support and that you provide more than 50% of his or her support must be completed and returned to the Fund Office. The affidavit must be signed and your signature must be witnessed by a notary public. The Fund Office may also require proof of residency along with a copy of your most recent tax return showing that you claim your disabled dependent as a dependent.

If you have any questions relating to any of these documents, please feel free to reach out to our Medical Department at 312-782-5442.

Intentionally Blank

Disabled Dependent Coverage Application

Section 1: Participant – *To be completed by you.*

Name:	**SSN:**	**Birth Date:**
Street Address:		**Apt #:**
City:	**State:**	**Zip Code:**
Cell Phone: ( )	**Home Phone: ( )**	**E-mail:**
Employer:	**Occupation:**	

☐ Please check box if the address indicated above is a new address

Dependent Information: *Please complete the section below with your disabled dependent's information*

Dependent Name: **Birth Date:**

Are insurance benefits provided for this dependent by any other group plan, including Medicare? ☐ *Yes ☐ No
**If yes, please provide a copy of the most current insurance card*

Signature: *Please read carefully. Sign and date below*

I hereby certify that these statements are true and complete to the best of my knowledge and I understand that their validity is one of the conditions of coverage. Any person who knowingly and with the intent to defraud any insurance company Employee benefit plan or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act which is a crime. In New York, the person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. In California, any person who knowingly files a statement of claim containing any false information or misleading information is subject to criminal and civil penalties.

Participant Signature: _____ **Date:** _____

Section 2: Attending Physician's Statement – *To be completed by your doctor. You are responsible for any cost associated with the completion of this form.*

Diagnosis

Primary:	**ICD.9**
Secondary:	**ICD.9**

Objective Findings *(which substantiate or contribute to this patient's condition including results of x-rays, MRIs, EKGs, etc.)*:

Subjective Symptoms:

Did this incapacity begin before the patient attained age 19? ☐ Yes ☐ No

Treatment

Does this condition require regular medical treatment? ☐ Yes ☐ No **If No, explain:*	**Date of first visit/treatment for this condition:**
Frequency of visits/treatment: ☐ Weekly ☐ Monthly ☐ Other: _____	**Date of most recent visit/treatment for this condition:**

Progress

Patient has:		Patient is:	
☐ Recovered	☐ Not Changed	☐ Ambulatory	☐ Home/Institution Confined
☐ Improved	☐ Regressed	☐ Wheelchair Confined	☐ Other:

In your opinion, will this patient become self-sufficient in the future? ☐ Yes ☐ No

Physical Impairment: *Please select ONE below.*

- ☐ No limitation of functional capacity; capable of any work
- ☐ Slight limitation of functional capacity; capable of light work
- ☐ Moderate limitation of functional capacity; capable of minimal work
- ☐ Severe limitation of functional capacity; incapable of minimal work

Mental/Nervous Impairment: *Please select ONE below.*

- ☐ Patient is able to function under stress and engage in interpersonal relationships *(no limitations)*
- ☐ Patient is able to function in situations and engage in most interpersonal relationships *(slight limitations)*
- ☐ Patient is unable to engage in interpersonal relationships *(marked limitations)*
- ☐ Patient has significant loss of psychological, physiological, personal and social adjustments *(severe limitations)*

Prognosis: *Please answer ALL questions.*

Is the patient currently disabled?	☐ Yes	☐ No
Is patient prevented from performing any gainful employment?	☐ Yes	☐ No
Is this disability expected to last for **at least 12 months**?	☐ Yes	☐ No
Do you expect a fundamental or marked change in the future?	☐ Yes	☐ No

Remarks:

Any additional pertinent information?

Physician Information:

Physician Name:		
Street Address:		
City:	**State:**	**Zip Code:**
Phone:	**Fax:**	
Physician's Signature:	**Date:**	

Return your completed Disabled Dependent Coverage Application to:

EIT BENEFIT FUNDS
SERVING THE CHICAGO ELECTRICAL INDUSTRY SINCE 1930

Disabled Dependent Affidavit

I hereby certify that (full name) is my legal Dependent as defined by the Plan and is incapable of self-support because of a documented disability.

I further certify that because of his or her condition, the following is true:

1. Does the Dependent Child rely on you, the Employee or Retiree, for more than 50% of his or her financial support and maintenance for the calendar year?

- ☐ Yes (must provide proof of your most recent annual tax return filed with the Internal Revenue Service).
- ☐ No

2. Does the Dependent Child reside in your home?

- ☐ Yes (must provide proof of Child's residency).
- ☐ No

3. Are insurance benefits provided for this dependent by any other other group plan, including Medicare?

- ☐ Yes (must provide a copy of the Child's most current insurance card or Medicare card).
- ☐ No

I hereby certify that the foregoing information is true and complete and I understand that if I have misrepresented or falsified any information or matter in connection with a my Disabled Dependent, the Trustees have the right to deny coverage for which he or she might otherwise be eligible for as a result of any misrepresentation or false information and may seek reimbursement for any claims paid during a period of misrepresentation.

_____ _____
Your Printed Name Your Social Security Number

_____ _____
Your Signature Date

Sworn to before me
On this day of _____ in the year of_____

_____
Notary Public

Return your completed Disabled Dependent Affidavit to:

EIT BENEFIT FUNDS • 6195 West 115th Street, Alsip, IL 60803 • (312) 782-5442 • Fax (312) 782-4431 • www.fundoffice.org