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**www.ufcwtrust.com**

# DISABLED OVERAGE DEPENDENT CHILD MEDICAL BENEFITS APPLICATION

For the purposes of determining if a child is eligible to be considered a Disabled Overage Dependent child by the Trust Fund Office please complete, sign, and return this form with all required documentation from the Document Checklist section to the Trust Fund. Under current plan rules, a Dependent child ceases to be an eligible Dependent when that child ages out of the plan, unless the child meets the requirements for a disability exception. In order for a Disabled Dependent to remain eligible for coverage, after aging out of the plan, a Dependent child must:

- have become totally and permanently disabled while enrolled and eligible for coverage under the Trust Fund before the age of 19 or age 24 if a full time student
- be granted Social Security Disability Benefits
- be unmarried and financially dependent on the member for support

## MEMBER SECTION (TO BE FILLED OUT BY MEMBER ONLY)

**1. MEMBER**

Member Name PLEASE PRINT:

Last Name:_____ First Name:_____ Middle Initial:_____

Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ or Member ID # _____

**2. DEPENDENT**

Name of Dependent PLEASE PRINT:

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth: _____/_____/_____ Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___
MM DD YYYY

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I hereby authorize any physician, any hospital or insurance company to furnish and disclose all known facts concerning this disability. A copy or photocopy of this authorization shall be as valid as the original.

MEMBER SIGNATURE: _____ Date: _____

## PHYSICIAN SECTION (TO BE FILLED OUT BY ATTENDING PHYSICIAN ONLY)

**1. DIAGNOSIS**

Disability that prevents the above patient from working or attending school: _____

Diagnosis Date: _____/_____/_____
MM DD YYYY

**REMARKS: (PLEASE PRINT)**

Attending Physician's SIGNATURE: _____ Date: _____

Federal ID#: _____ Telephone #: _____

Attending Physician's name PLEASE PRINT: _____ Degree:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

## DOCUMENT CHECKLIST

Below is a list of the required documents when applying for Disabled Overage Dependent Status for your child: These must be included with your application.

- Social Security Disability Benefit verification letter
- Page 1 of your most recently filed Federal Tax Return
- All documents from one of the below categories to which the child belongs (only if not previously submitted):
  1. Natural Child County-Issued Certified Birth Certificate
  2. Stepchild County-Issued Certified Birth Certificate, and County-Certified Marriage Certificate with Natural Parent
  3. Adopted Child Court Adoption Papers
  4. Foster Child Foster Home License, and Legal Guardianship papers for the Child