IOWA | Department of Administrative Services

KIM REYNOLDS, GOVERNOR
CHRIS COURNOYER, LT. GOVERNOR

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Disabled Dependent Certification Form

Employee Name: _____ Employee ID: _____

Dependent Name: _____ Date of Birth: _____

A dependent that is over the age of 26 and is totally and permanently disabled (physically or mentally) may be covered on your medical and/or dental insurance. The dependent must be claimed on the employee's or retiree's federal tax return; and enrolled in and receiving Medicare disability benefits **or** enrolled in and receiving Social Security benefits due to disability.

Eligibility:

- An unmarried child that is totally and permanently disabled may be covered on your medical and/or dental insurance.
- The disability must have existed before the child turned age 26; while they were an eligible dependent or while they were an eligible full-time student.
- If the disabled dependent is age 29 or older, a copy of the dependent's *Social Security Administration Benefit Verification Letter* will be required.

Disability onset date for this dependent: _____

Is this dependent married?

☐ Yes ☐ No If yes, what is the date of marriage? _____

Is this dependent claimed on your prior year's federal tax return due to disability?
NEW! If yes, documentation is required. Submit a copy of the Form 1040 from your prior year's federal tax return with your disabled dependent's name listed. Sensitive information can be redacted.

☐ Yes ☐ No

Is this dependent enrolled in and receiving Social Security benefits due to disability?
If yes, submit a copy of the dependent's *Social Security Administration Benefit Verification Letter* that is dated within the past 12 months. This letter is required if the dependent is age 29 or older.

☐ Yes ☐ No

Is this dependent eligible for and receiving Medicare benefits due to disability?
If yes, submit a copy of the dependent's Medicare card (front and back).

☐ Yes ☐ No

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Important:
Documentation must be submitted annually for your disabled dependent to be enrolled in medical and/or dental insurance.

Once coverage has started, you will not be able to make a change to your benefits until the next open enrollment, unless your disabled dependent experiences a qualifying life event.

If at any time during the year, your dependent is no longer considered totally or permanently disabled or gets married, they will no longer be eligible to remain covered on your medical and/or dental insurance. **It is your responsibility** to notify your HRA in writing within 30 calendar days.

For additional information, refer to Disabled Dependent Certification.
If you have any questions, please contact your Human Resources Associate (HRA).

Certification:
I am providing this information to my employer for insurance enrollment. By signing and submitting this form, I certify that all of the statements on this form are true. I understand that fraud or a material misrepresentation regarding dependent eligibility for coverage will result in termination of coverage retroactive to the date that coverage began. I understand that I will be responsible for the cost of services provided during the period when coverage was in effect while the dependent was not eligible for coverage.

In addition, I certify that this disabled dependent is not married. If my disabled dependent's status changes, I will notify my employer immediately by submitting that information in writing to my HRA.

Employee's Name (Printed): _____

Employee's Signature: _____ Date: _____

Please submit this completed form and the required documentation to your HRA.