IOWA
Department of
Administrative Services

Certification of Dependent Disability

Employee Name: _____
Dependent Name: _____
Dependent DOB: _____
Department: _____

An unmarried child who is totally and permanently disabled may be enrolled in health and dental insurance regardless of age (The disability must have existed before the child, while an eligible dependent, turned age 26 or while a full-time student.) By age 29, Medicare coverage or SSI disability will be required to maintain active coverage.

Totally and permanently disabled (physically or mentally) is defined as: claimed as a dependent on the employee's, plan member's, subscriber's, policyholder's, or retiree's tax return; and enrolled in and receiving Medicare disability benefits or enrolled in and receiving current SSI recipient due to disability.

Complete the following information on your disabled dependent who is age 27 or older.

1. Is the dependent married?
   □ **No** □ **Yes**
   If yes, what was the date of marriage? ___ / ___ / ____

2. What was the date of onset of this dependent's disabilities diagnosis? ___ / ___ / ____

3. Is this dependent claimed as a dependent on your most recent Federal Tax Return due to the presence of this disability?
   □ **No** □ **Yes**

4. Is the dependent eligible for and receiving Social Security Income due to this disability?
   □ **No** □ **Yes**
   If yes, please submit documentation verifying that Social Security benefits are received due to this disability.

5. Is this dependent eligible for and receiving Medicare benefits due to this disability?
   □ **No** □ **Yes**
   If yes, please provide the dependent's Medicare number along with documentation verifying that Medicare benefits are being received due to this disability. Medicare number: _____

To the best of my knowledge, all statements and answers above are complete and true. I understand fraud or a material misrepresentation regarding dependent eligibility for coverage will result in a termination of coverage of the dependent retroactive to the date eligibility was lost and I will be responsible for the cost of services provided during the period when coverage was in effect while dependent was not eligible for coverage.

If my dependent's status changes, I will notify my agency's Human Resources Associate immediately.

Employee Name (Printed) _____

Employee Signature _____

Signature Date: _____

** Enrollment is subject to all of the State of Iowa Group Insurance Plan rules and regulations. Once you enroll your child, you will not be able to cancel their coverage until the next annual Open Enrollment period unless there is a qualifying event which would allow for cancellation.*

Please submit the completed form to your Human Resources Associate.