Certification of Dependent Disability

Your 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 26 or older.

Employee/Retiree Name: _____

Employee/Retiree Social Security Number: _____

Dependent Name: _____ Date of Birth: _____

Dependent Sex: ☐Female ☐Male

Relationship to Employee/Retiree: _____

Dependents Social Security Number: _____

Dependents Marital Status: ☐Single ☐Married☐ Divorced ☐Separated

Does this dependent reside with you? ☐Yes ☐No

Do you provide 100% of the dependent's support? ☐Yes ☐ No

Is this dependent a current SSI recipient due to disability? ☐Yes ☐No

(Please enclose letter of determination from SSI)

Does this dependent have Medicare A or Part B?☐ Yes☐ No

Medicare Number: _____

Effective date for Hospital (Part A): _____

Effective date for Hospital (Part B): _____

When did the disability begin? _____

(Please enclose Medicare letter)

Is this dependent insured by: ☐No other plan ☐Medicaid (number _____) ☐Other Insurance plan. Identify plan and the name of the subscriber. Plan name: _____ Name of Subscriber: _____

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 Enrollment and Change Period unless there is a qualifying event that would allow for cancellation.*