Disabled Dependent Certification

TO BE COMPLETED BY THE PLAN PARTICIPANT

After completing the following section, forward this form to your physician for completion.					
1 Plan Participant Last Name	First Name		M.I.	1a. Identification / SSN Number	
2. Home Address	City			State	ZIP Code
3. District Name				3a. Group Number: **50000**	
4. Dependent's Name		4a. Dependent's Birth Date		4b. Dependent's Marital Status	
5. Does the dependent qualify to be claimed on your federal income tax return?				❑ Yes	❑ No
6. Is dependent employed?	❑ Yes	❑ No	6a. Date of Hire	6b. Number of hours employed per week.	
6c. Describe nature of duties					
I certify that the above information is correct and authorize the release of medical information requested with respect to this certification. Plan Participant Signature			Date Signed		

TO BE COMPLETED BY ATTENDING PHYSICIAN

An unmarried dependent child who is incapable of self-support due to a continuously disabling illness or injury may be continued as a family member on the parent's Health Plan. Your medical statement will help us determine the eligibility of this dependent.			
1. List the ICD10 codes relevant to the disabling condition			
2. Describe the disabling condition			
3. To what extent does the disability limit normal activity?			
4. What is your prognosis, including your estimates of length of time this disability may be expected to continue?			
Physician's Name	Physician's Signature		Date Signed
Physician's Address	City	State	ZIP Code

Please return the completed form to:

90 Degree Benefits
PO Box 54192
Lubbock, TX 79453
Phone: 888-803-0081 / Fax: 806-698-5823
careconnect@90degreebenefits.com