



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?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Is dependent employed?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 21548

Eagan, MN 55121

Phone: 888-803-0081 / Fax: 806-698-5823

careconnect@90degreebenefits.com

