



## Affidavit of Disabled Dependent Child Eligibility

**Instructions:** To document and verify a disabled dependents' relationship to the plan member (employee), this affidavit must be submitted to the Independent Colleges and Universities Benefits Association (ICUBA). The signature of a physician who can attest that the dependent qualifies as an overage disabled child is also required. Along with this affidavit, the plan member may be required to submit other information as outlined by the plan documents governing the medical insurance plan at your member school.

- DO NOT SUBMIT MEDICAL RECORDS OR INFORMATION COPIED DIRECTLY FROM MEDICAL RECORDS
- Ensure all sections of this form are completed before uploading this form to your employer file

**In order to continue coverage for adult disabled dependents, the following criteria must be satisfied;**

- Dependent must be a child of the plan member ("child" includes a plan member's natural child, legally adopted child, stepchild, foster child, and any child with proof of legal guardianship by the plan member).
- Dependent must be 26 or older.
- Dependent must be mainly dependent on the plan member for support.
- Dependent must be unable to provide self-support due to a mental or physical disability.
- Dependent must be claimed as the plan member's dependent for income tax purposes.\*

*\*If not claimed as such dependent for income tax purposes, is eligible for Social Security income or Supplemental Security Income (SSI) as a disabled person or is working in supported employment which may offset the Social Security or SSI.*

### PART A: Plan Member and Dependent Information

Employee First Name:

Employee Last Name:

Employee Date of Birth:

Member School:

Dependent First Name:

Dependent Last Name:

Dependent Date of Birth:

### PART B: Overage Disabled Child Authorization

**The overage disabled child, or person authorized to act on their behalf,** is to complete the information requested in this section **prior** to providing this form to the physician for completion:

I hereby authorize my attending physician, \_\_\_\_\_, to furnish facts concerning my disability. I agree that a photocopy of this authorization shall be as valid as an original. I understand that if I do not sign this authorization, or if I revoke or modify it, ICUBA or its member schools, may not be able to determine my eligibility as an overage disabled child and that my request may be denied. I also understand that ICUBA will keep confidential the information which is provided pursuant to this authorization, and that it will be used solely to determine and act upon my request for this benefit.

\_\_\_\_\_  
Signature of Overage Disabled Child **OR**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Person authorized to act on their behalf

\_\_\_\_\_  
Relationship to the overage disabled Child

## PART C: Physician Information and Attestation

### HEALTHCARE PROVIDER:

The patient requests you to complete this medical certification of disability and incapacity of self-support. It will assist ICUBA in processing their claim for health insurance as a disabled child under their parent's health plan. By providing the medical information promptly, you will help the patient expedite the claims process. **Please return the form to the patient upon completion.** For purposes of this benefit, an ICUBA member can retain their eligibility for health benefits as a family member if they are unmarried and incapable of self-support (i.e. not capable of engaging in any substantial gainful activity) due to physical or mental disability which existed continuously prior to becoming 26 years of age.

Based upon your medical or psychiatric opinion, does the patient currently have a physically or mentally disabling injury, illness, or condition?

- YES, the patient's current disability is of a permanent or extended duration and, consequently, the patient is not and will not be capable of self-support within the foreseeable future.
- NO, the patient does NOT have a physically or mentally disabling injury, illness or condition.

I certify that, based upon my examination of the patient, the above statements truly describe the patient's disability and their capability of self-support.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

**PRINT, TYPE or STAMP PHYSICIAN'S NAME AS SHOWN ON LICENSE and THEIR ADDRESS, TELEPHONE AND FAX NUMBERS:**

\_\_\_\_\_  
PHYSICIAN'S NAME AS SHOWN ON LICENSE

\_\_\_\_\_  
ORIGINAL SIGNATURE OF ATTENDING PHYSICIAN

\_\_\_\_\_  
LOCAL ADDRESS

\_\_\_\_\_  
STATE LICENSE NUMBER

\_\_\_\_\_  
CITY, STATE ZIP

\_\_\_\_\_  
PHONE NUMBER

\_\_\_\_\_  
DATE

\_\_\_\_\_  
FAX NUMBER

## PART D: Plan Member Signature

By signing this affidavit, I attest that I have reviewed the Plan Document for and The Independent Colleges and Universities Benefits Association Definitions of Dependents and Documentation Required and that the information I am submitting is true and accurate. I understand that if insufficient or incomplete information is submitted, coverage may not be extended to my dependent. I understand that providing false or misleading information may result in termination of coverage for myself and my family members, charges to recover paid premium costs and costs of services, and/or disciplinary action.

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date

**Complete this form and upload it to your Employee File in the ICUBA Benefits Portal at <http://icubabenefits.org>**