INSURANCE MANAGEMENT SERVICES
(806) 373-5944 • 1-800-687-5944
www.imstpa.com • P.O. Box 15688 • Amarillo Tx 79105

Dependent Disability Information Form

1. EMPLOYEE INFORMATION:

Employee Name: _____Employee SSN:_____

Address: _____City: _____ State: ____ Zip:_____

Phone:_____ E-mail Address:_____

2.DISABLED DEPENDENT CHILD INFORMATION:

Dependent Name (Last, First, MI):_____Date of Birth:_____

1.) **Relationship to Employee**: ☐ Biological ☐ Adopted Child ☐ Stepchild ☐ Unlimited Guardianship

2.) **Is this dependent child**: ☐ Single ☐ Married ☐ Divorced

3.) **Is this dependent child employed**: ☐ Full-time ☐ Part-time (☐ hours per week) ☐ Not employed

4.) **Income Tax Status**:
Was this dependent claimed as a dependent on the employee or employee's spouse's most recent Federal Income Tax filing?

☐ Yes ☐ No

If no, would the dependent qualify to be claimed? Explain:
_____
_____

Has anyone else claimed this dependent for Federal Income Tax purposes? ☐ Yes ☐ No

If Yes, Explain:
_____
_____

5.) Is this dependent residing in the employee's household? ☐ Yes ☐ No

If no, where is this dependent residing?
_____
_____

6.) Is this dependent presently insured by:

☐ Medicare ☐ Medicaid ☐ Other Medical Plan ☐ No Other Plan

7.) Does dependent have personal resources (settlement, trust fund, etc.) that may provide financial support?

☐ Yes ☐ No

If Yes, Please Explain:
_____
_____

PHYSICIAN STATEMENT: (To be completed by the dependent child's physician)

Employee Name: _____
Dependent Name: _____
Disabled dependent Diagnosis: _____

The dependent's disability has been continuous since: ☐ Mo. ☐ Day ☐ Year

Indicate the dependent's prognosis for recovery in terms of months or years:

_____
_____

Describe symptoms that prevent dependent from engaging in self-sustaining employment in detail (i.e. extent of learning disability, etc.): _____
_____
_____
_____

Is the dependent now capable of self-sustaining employment because of a physical or mental disability?

☐ Yes ☐ No

Name of Physician (print or type): _____
Physician's Signature: _____
Date: _____/_____/_____

Eligibility for Disabled Dependent Coverage

Dependent children that are eligible for Disabled Child Coverage under this health plan are those children who are:

An Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age as stated in the numbers above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age as stated in the numbers above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age as stated in the numbers above. The time limit for written proof of incapacity and dependency is 31 days following the original eligibility date for a new or re-enrolling Employee. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

3. EMPLOYEE CERTIFICATION:

I certify that the information I have provided in this application for my disabled dependent child is true and complete. I understand that any false information or statements will be grounds for my employer to void my health plan coverage and/or terminate my employment.

I certify that this disabled dependent meets Eligibility for Disabled Child Coverage.

Employee Signature: _____
Date: _____/_____/_____

For any questions please call (800) 687-5944. This form, along with any supporting documentation, certifying that the child is fully disabled must be submitted to Insurance Management Service or your employer for review no later than 30 days prior to the date that coverage as a dependent would have ceased. Proof that the child remains fully disabled and is dependent on the employee for financial support may be required at reasonable intervals.