HS

University of Michigan
Disabled Dependent Certification

BTT Use Only
Event Date _____
Input Elections _____

Please print all information in **black** ink.

1. U-M Faculty or Staff Member Information.

Name (Last, First, Middle Initial)	UMID	U.S. Social Security Number (If UMID is Unknown)
Street Address	City, State, Zip	
Email Address	Home Phone Number	Daytime Phone Number

2. Disabled Dependent Child Information. Please do not report genetic information or family medical history on this form.

Name (Last, First, Middle Initial)	Date of Birth	Social Security Number

1. Relationship to Employee: ☐ Biological or Adopted Child ☐ Stepchild ☐ Other: _____
2. Is this dependent: ☐ Single ☐ Married ☐ Divorced
3. Is this dependent employed: ☐ Not Employed ☐ Part-time (____ hours per week) ☐ Full time Employer: _____

If not employed, how does this condition prevent him/her from working? _____

4. Income Tax Status

a) Did you claim this dependent as an eligible exemption on your most recent Federal Income Tax return? ☐ Yes ☐ No

If no, did you provide over 50% of this dependent's total support last year? ☐ Yes ☐ No

b) Will you claim this dependent as an eligible exemption when filing your Federal Income Tax for the current year? ☐ Yes ☐ No

If no, will you provide over 50% of this dependent's total support this year? ☐ Yes ☐ No

c) Has anyone else claimed this dependent for Federal Income Tax purposes? ☐ Yes ☐ No If yes, explain _____

5. Is this dependent residing in your household? ☐ Yes ☐ No If no, where is the dependent residing? _____
6. Is this dependent now enrolled as a student? ☐ Not a student ☐ Part-time student (___ hours per week) ☐ Full-time Student

If a student, name of school: _____

7. Is this dependent presently insured by: ☐ No other plan ☐ Medicare (Medicare Number_____) Medicaid

☐ Other health plan. Identify plan and the name of the subscriber. Plan name: _____

Name of Subscriber: _____

3. General Provisions, Authorization and Confirmation of Benefits.

By my signature below to enroll in benefits at the University of Michigan, I understand, agree and/or confirm that:

- I authorize any doctor, hospital, or other provider who renders service(s) to me or my eligible dependents to furnish to the medical insurance plan I select any information that plan requests related to medical information, claims, and other insurance payments.
- Upon request, I will furnish a copy of the section of my IRS Form 1040 listing dependents, court orders establishing guardianship or adoption, and/or the birth certificate of any individual for whom I seek benefits.
- If there is any change in the status of any of the individuals listed on this form, I will be responsible for notifying the university within 30 days of such change.
- I certify that I understand and affirm under penalty of perjury that the preceding statements are true and complete to the best of my knowledge. I further understand that any misrepresentation of these statements may result in serious consequences, including loss of benefits, discipline or appropriate legal actions.
- Upon request, I will submit to my health plan clinical documentation, from a contracted physician in my health plan, of the child's continued and permanent disability.

_____ _____

Signature of Faculty or Staff Member Date Signed

HS Employee Name _____ UMID _____

Physician's Certification of Disability

Please answer all of the questions below. Please do not report genetic information of family medical history on this form.

1. Patient's Name: _____ Patient's Birth Date: _____
2. Diagnosis: _____
3. Date of onset of disability: _____
4. Has disability existed continuously since first diagnosed? ☐ Yes ☐ No If no, please explain: _____
5. Degree of physical disability: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Profound
6. Degree of mental disability: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Profound
7. In your professional opinion, does the disability prevent the patient from engaging in any substantial gainful activity?
   ☐ Yes ☐ No If yes, describe in detail the patient's specific physical and / or mental limitations that prevent him or her from engaging in any substantial gainful activity: _____
8. In your professional opinion, could the disability improve? ☐ Yes ☐ No
   If yes, how long could the disability be expected to prevent the patient from engaging in any substantial gainful activity?
   ☐ Less than 6 months ☐ 6 to 12 months ☐ 12 to 18 months ☐ Other: (Describe) _____
9. How long have you treated this patient, and when did you last see him/her? _____

I certify that, to the best of my knowledge and belief, the information I have provided is true and accurate.

Physician's Signature _____ Date _____

Please print information below.

Physician Last Name	First Name	MI	Physician Telephone Number	
Business Address	**City**		**State**	**Zip Code**

HUMAN RESOURCES
BENEFITS OFFICE
UNIVERSITY OF MICHIGAN

Questions?
If you have questions, visit hr.umich.edu/benefits-wellness, or call the SSC Contact Center at 734-615-2000 or 866-647-7657 (toll free for off-campus long-distance calls within the U.S.) Monday through Friday from 8 a.m. to 5 p.m.

How to Return Your Signed and Completed Form

By FAX

734-936-8835
Attention: Kate Van Valkenburgh

Keep a copy of the fax transmission report with your form in your records.

By Mail
Make a copy for your records and send the original by **Campus Mail or U.S. Mail to:**

University of Michigan
Benefits Office
Wolverine Tower – Low Rise G405
3003 South State Street
Ann Arbor, MI 48109-1281
Attention: Kate Van Valkenburgh