

University of Michigan
Disabled Dependent Certification

BTT Use Only Event Date _____ Input Elections _____
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Application for extended coverage due to a dependent's disability must be submitted within 31 days of the date the dependent reaches age 26. 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: <input type="checkbox"/> Biological or Adopted Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other: _____ 2. Is this dependent: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced 3. Is this dependent employed: <input type="checkbox"/> Not Employed <input type="checkbox"/> Part-time (____ hours per week) <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, did you provide over 50% of this dependent's total support last year? <input type="checkbox"/> Yes <input type="checkbox"/> No b) Will you claim this dependent as an eligible exemption when filing your Federal Income Tax for the current year? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, will you provide over 50% of this dependent's total support this year? <input type="checkbox"/> Yes <input type="checkbox"/> No c) Has anyone else claimed this dependent for Federal Income Tax purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain _____		
5. Is this dependent residing in your household? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, where is the dependent residing? _____ 6. Is this dependent now enrolled as a student? <input type="checkbox"/> Not a student <input type="checkbox"/> Part-time student (____ hours per week) <input type="checkbox"/> Full-time Student If a student, name of school: _____ 7. Is this dependent presently insured by: <input type="checkbox"/> No other plan <input type="checkbox"/> Medicare (Medicare Number _____) Medicaid <input type="checkbox"/> Other health plan. Identify plan and the name of the subscriber. Plan name: _____ Name of Subscriber: _____		

3. General Provisions, Authorization and Confirmation of Benefits.

<p>By my signature below to enroll in benefits at the University of Michigan, I understand, agree and/or confirm that:</p> <ul style="list-style-type: none"> 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. 	
<p>_____ Signature of Faculty or Staff Member</p>	<p>_____ Date Signed</p>

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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	



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