

University of Virginia Health Plan

Disabled Child Application and Certification

PART I must be completed by the Participant and PART II must be completed by the attending physician. Please forward the completed form and medical records to: UVA Benefits Division, Attn: Margaret Marsh, 914 Emmet Street, PO Box 400127, Charlottesville, VA 22904-4127.
The application and records must be received and approved by the Claims Administrator PRIOR to the dependent's 23rd birthday.

Part I

PARTICIPANT'S NAME (Print Last, First, Middle Initial)		Participant's Social Security Number	
ADDRESS (Number, Street, City, State, and ZIP Code)			
Full Name Of Dependent Child		Child's Date Of Birth	Child's Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
Relationship of Child to Participant		Child's Age When Disability Occurred	Child's Sex <input type="checkbox"/> Female <input type="checkbox"/> Male
Does your child rely upon you for support? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did you claim your child as a dependent on last year's federal tax forms? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the child covered under Medicare? If yes, please send a copy of the Medicare card. <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the child currently employed, or has the child ever been employed in the past? If "YES", give name(s) and address(es) of employer(s) and date(s) employed. <input type="checkbox"/> Yes <input type="checkbox"/> No			
I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.			
_____		_____	_____
Participant's Signature		Date Signed	Daytime Telephone Number

Part II

To be completed by an attending physician.

Is the child incapable of self-support because of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has such disability existed continuously since before the child attained age 23? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PRIMARY DIAGNOSIS:			
SECONDARY DIAGNOSIS:			
How does the illness interfere with gainful employment?			
How long do you anticipate such disability may continue? (Permanently) (Temporarily) If Temporarily, 6 months, 1 year, 2 years, etc.)			
Assessment based upon (circle one or more): Physical Exam/Review of Medical Records/Appropriate Tests and Diagnostic Procedures Please attach a copy of medical records to further explain the disability and substantiate the severity of limitations.			
I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY PROFESSIONAL KNOWLEDGE.			
_____		_____	_____
Name of Physician (print or type)		Degree	Physician's Signature

Date			
Address of Physician (print or type)			
Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be liable for substantial civil penalties.			