DISABLED DEPENDENT CERTIFICATION FORM INSTRUCTIONS

An eligible dependent child(ren) can be enrolled in the Flexible Benefits Program until he/she turns age 26. Dependent children who are disabled prior to age 26 and incapable of self-sustaining employment by reason of mental incapacity or physical disability may be eligible to continue coverage after their 26th birthday if proof of the child's disability is provided within 30 days of the child turning 26 and approved by Human Resources Administration (HRA).

If the disabled dependent's coverage with the State Health Benefit Plan (SHBP) has been approved beyond the age of 26, only complete **Section A** of the Disabled Dependent Certification Form, attach a copy of SHBP's approval letter and sign the form. This information must be submitted with 30 days of the dependent turning age 26.

Note: **Disabled dependents' certifications approved by SHBP do not transfer to the Flexible Benefits Program. Failure to certify or re-certify your disabled dependent with HRA, will result in loss of the dependent's coverage permanently.**

The Disabled Dependent Certification Form must be completed and returned within 30 days of the disabled dependents 26th birthday or when requested by the Flexible Benefits Program to continue coverage or recertify your dependent.

Please email the completed Disabled Dependent Certification form & supporting documents to:

HRA.flexbenefits@doas.ga.gov

or mail to:

Department of Administrative Services
Human Resources Administration
200 Piedmont Road, S.E.
Suite 1206, West Tower
Atlanta, GA 30334-9010

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DISABLED DEPENDENT CERTIFICATION FORM

Please complete Sections A and B. This form must be signed by the employee or the dependent's personal representative and the attending physician. Incomplete or illegible forms will be returned and will delay the review process.

IS THE DEPENDENT CURRENTLY COVERED UNDER THE STATE HEALTH BENEFIT PLAN? ____YES ____ NO

SECTION A: GENERAL INFORMATION		
Employee's Name (First, Last)	SSN	
Street Address	City	
State	Zip Code	Phone
Dependent's Name (First, Last)	Dependent's Birthdate	Relationship to Employee

SECTION B: DISABLED DEPENDENT CERTIFICATION (*To be completed by the dependent's Physician.)*	
1. Is the dependent incapable of self-sustaining employment by reason of mental incapacity or physical disability? ☐ Yes ☐ No	2. What was the dependent's age when the disability occurred?
3. Nature of the Disability (provide as much detail as possible)	

4. Prognosis: Is the impairment or disability temporary or permanent? ☐ Temporary ☐ Permanent If temporary, please provide the date the dependent will be capable of self-sustaining employment. _____
5. Name of Physician (print) Phone Number
6 Address of Physician

I HEREBY CERTIFY THAT THE ABOVE INFORMAITON IS CORRECT TO THE BEST OF MY KNOWLEDGE.

_____

Signature of Physician Date

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE THE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.

_____

Signature of Employee Date