

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 31 days of the child turning 26 and approved by Human Resources Administration (HRA).

Please complete the entire form and attach a copy of SHBP's approval letter, if applicable. The form must be signed and dated by you and the attending physician. This form must be submitted with 31 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 31 days of the disabled dependents 26th birthday, loss of coverage elsewhere or when requested by the Flexible Benefits Program to continue coverage or recertify your dependent.

Please submit 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

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 <i>(To be completed by the dependent's Physician.)</i>	
1. Is the dependent incapable of self-sustaining employment by reason of mental incapacity or physical disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. What was the dependent's age when the disability occurred?
3. Nature of the Disability (provide as much detail as possible) <div style="border: 1px solid black; height: 100px; margin-top: 5px;"></div>	

4. Prognosis: Is the impairment or disability temporary or permanent? <input type="checkbox"/> Temporary <input type="checkbox"/> 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 INFORMATION 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