OptimaHealth

DISABLED DEPENDENT CERTIFICATION FORM

(To determine eligibility for coverage of dependent children over age 26)

Email completed forms to: LARGE_GROUP_ENROLLMENT@Sentara.com

SECTION A: GENERAL INFORMATION ***(to be completed by EMPLOYEE)***		
1. Employer Name	2. Group Number	
2. Name of Policyholder – Employee (First Last)	3. ID Number	
3. Address		
4. Dependent's Name (First Last)	5. Dependent's Date of Birth	
6. Dependent's Relationship to Policyholder		
7. Was this dependent covered under your prior insurance plan? If yes, since what date?		
8. Is this dependent claimed on your tax return?		
I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUIRED.		
9. Signature of Employee	10. Date	11. Employee Phone Number

SECTION B: DISABLED DEPENDENT CERTIFICATION ***(To be completed by the dependent's Physician)***		
1. Is dependent incapable of self-support because of a disability?	2. Dependent's age when disability occurred	
12. Primary Diagnosis		
4. Nature of disability (please provide as much detail as possible). Attach additional documents, if needed.		
13. Signature of Physician	14. Date	15. Physician Phone Number
7. Printed Name and Address of Physician		