Sentara Health Plans

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	
3. Policyholder Name–Employee (First Last)	4. ID Number	
5. Address		
6. Dependent's Name (First Last)	7. Dependent's Date of Birth	
8. Dependent's Relationship to Policyholder		
9. Was this dependent covered under your prior insurance plan? If yes, since what date?		
10. 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.		
11. Employee Signature	12. Date	13. Employee Phone Number
SECTION B: DISABLED DEPENDENT CERTIFICATION *(To be completed by the DEPENDENT'S PHYSICIAN)*		
14. Is dependent incapable of self-support because of a disability?	15. Dependent's age when disability occurred	
16. Primary Diagnosis		
17. Nature of disability (please provide as much detail as possible). Attach additional documents if needed.		
18. Physician Signature	19. Date	20. Physician Phone Number
21. Printed Name and Address of Physician		