# PEBTF

**150 South 43rd Street Suite 1**
**Harrisburg, PA 17111-5700**

**Local: 717-561-4750**
**Toll Free 800-522-7279**

## PEBTF DISABLED DEPENDENT CERTIFICATION

Note: All information requested below MUST be completed. If more space is needed, please attach a separate sheet

**EMPLOYEE/RETIREE INFORMATION:**

**Name (First, Middle Initial, Last): _____**

**Address: _____Home Phone: _____**

**Date of Birth (MM/DD/YYY): _____ Employee #: _____**

**DEPENDENT CHILD INFORMATION:**

**Name (First, Middle Initial, Last): _____**

1. Date of Birth (MM/DD/YYYY): _____
2. Relationship to member: ☐Child ☐Step child ☐Other (specify) _____
3. Is Dependent employed? ☐ Yes ☐ No Was Dependent ever employed? ☐ Yes ☐ No
4. If Dependent is/was employed: ☐ Full time ☐ Part time

| Employer Name | Dates of Employment | Hours Worked Weekly | Hourly Wage | Description of Duties |
|---|---|---|---|---|
| | | | | |

5. Does Dependent have other medical coverage? ☐ Yes ☐ No

   If yes, please provide name of insurance company and group, certificate or agreement number below:

   _____

6. Dependent's age when disability occurred: _____
7. Is the dependent child currently residing in your household? ☐ Yes ☐ No

   If no, please explain below:_____

8. Are you or your spouse/domestic partner responsible for more than 50% of the dependent's financial support?

   ☐ Yes ☐ No

9. Was the dependent child claimed on your or your spouse/domestic partner's federal income tax return?

   ☐ Yes ☐ No, please explain_____

   **If yes, a copy of your return including the signature page must be included when returning the recertification.**

**MEMBER'S AUTHORIZATION**: I HEREBY CERTIFY THAT THE ABOVE LISTED INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION. I UNDERSTAND THAT RECERTIFICATION MAY BE REQUESTED IN THE FUTURE.

**NOTE:** Eligibility for benefit coverage as a disabled dependent and continuance of same is based on the nature of disability, duration and prognosis. Disabled dependents are subject to recertification by the PEBTF. Failure to provide the necessary certification when requested to substantiate eligibility will result in the termination of a dependent's coverage. If or when your dependent no longer meets the eligibility requirements shown above, he/she has the right to continue coverage on a self-pay basis for up to 36 months

**Member's Signature _____** **Date signed _____**

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# PEBTF DISABLED DEPENDENT CERTIFICATION (Continued)

## THIS SECTION TO BE COMPLETED BY ATTENDING PHYSICIAN

**Dependent Name: _____**

1. Is the dependent capable of being gainfully employed? ☐ Yes ☐ No

2. Does the disability restrict their usual daily activities such as play and/or school or work attendance? ☐ Yes ☐ No

3. When did you first treat the dependent for the disability? _____

4. Has the disability existed continuously since before the dependent attained age 26? ☐ Yes ☐ No

5. Diagnosis (please note below):
   _____

6. Nature of disability (explain in detail the nature, severity and extent of the disability, how the disability affects the dependent's functional abilities, decision making capacity, etc. **Diagnosis alone does not provide sufficient information to support a determination of disability:**

   _____
   _____
   _____
   _____
   _____

7. Treatment/medication rendered to patient and response to the treatment/medication:

   _____
   _____
   _____
   _____

8. Is dependent's disability considered: ☐ Temporary ☐ Permanent
9. Is the disability considered: ☐ Total disability ☐ Partial disability

10. Physician Name: _____ Telephone: _____

    Address: _____

    City: _____ State: _____ Zip Code: _____

11. Physician Signature:_____ Date: _____

**Please include any/all prior evaluations/assessments the dependent may have had to validate the disability.**