IB8
09/25

State Employees' Insurance Board
Incapacitated Child Certification Form

Please read the conditions of eligibility carefully before completing this form.

Your incapacitated child over age 25 will be considered for coverage provided the incapacitation occurred prior to the child's 26th birthday and the child is:(1) unmarried; (2) permanently mentally or physically disabled or incapacitated; (3) had the condition prior to the dependent's 26th birthday; (4) incapable of self-sustaining employment; (5) dependent on the subscriber for 50% or more financial support; (6) otherwise eligible for coverage as a dependent except for age; (7) covered as a dependent on your Plan immediately prior to the child's 26th birthday, and (8) not eligible for any other group health insurance benefits.

Complete and sign the front of this form. Your child's physician must complete and sign the back then send the completed form to the SEIB Wellness Department.

Subscriber's Information

Name (First, Middle Initial, Last):			Contract Number:		Date of Birth:
Street Address:			City:	State:	ZIP Code:
Home Phone Number:	Cell Phone Number:	Work Phone Number:	Email Address:		

Dependent Child's Information

Name (First, Middle Initial, Last):	Date of Birth:	Gender:	Marital Status:

When did the incapacitation begin?

Is the Dependent residing in your household? □ Yes □ No If no, where does the dependent reside?

Does the Dependent rely on you, the subscriber, for more than 50 percent financial support? ☐ Yes ☐ No
If yes, attach a copy of your latest tax return or other supporting financial documentation.

Has the Dependent ever been employed? ☐ Yes ☐ No If yes, please complete the following employment section:

Employer:	Job Description:	Period of Current/Latest Employment:	Avg. Weekly Hours:

Other Benefit Information

Is this Dependent covered by any other health insurance benefits, including Medicare or Medicaid? ☐ Yes ☐ No If yes, please complete the following:

Name of Contract Holder	Contract Holder Date of Birth	Group #	Insurance Contract #

Name of Insurance Company and Types of Coverage (Check all that apply) ☐ Hospitalization ☐ Prescription Drugs ☐ Dental ☐ Doctor's Visits

Has this Dependent applied for Social Security Income? ☐ Yes ☐ No

If yes, please indicate the date and status of application:

Is the child eligible for care under any federal, state, or local program?
☐ Yes ☐ No

If yes, please provide details of the additional care.

I hereby certify that all information provided is accurate and complete. I understand that any misrepresentations may result in the forfeiture of insurance coverage and I will be personally liable for all claims related to such misrepresentations. I hereby authorize any physician or other person who has attended my above-named child or who may hereafter attend or examine such child to disclose any knowledge or information acquired by him/her to the SEIB or representatives acting on the SEIB's behalf. Any charges for providing this information will be my responsibility. I understand that enrollment for this child under my coverage may remain in force so long as this dependency exists and while my coverage is of the type that may include such a child. I further understand the SEIB shall have the right to require recertification as to eligibility for continuation of dependency coverage as often as SEIB may reasonably require.

Subscriber Signature: _____ Date: _____

State Employees' Insurance Board
201 South Union Street, Suite 200 • Post Office Box 304900
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State Employees' Insurance Board
Incapacitated Child Certification Form- Physician's Questionnaire
This section to be completed by dependent child's attending physician.

Dependent Child's Name (First, Middle Initial, Last):	Date of Birth:
Date incapacitation began:	Date you last examined the Dependent Child:

Diagnosis: _____

Is incapacitation related to behavioral health diagnosis or intellectual disability? ☐ Yes ☐ No

If yes, is dependent followed by a behavioral health provider? ☐ Yes ☐ No

Please summarize most recent medical and/or behavioral health assessment and treatment recommendations related to incapacity: _____

_____

_____

_____

Does the child suffer from a severe organic psychiatric disease that results in one or more of the following?
(Please check those descriptions which are applicable and comment if necessary)

☐ Unmanageable hallucinations, loss of touch with reality, paranoia, and or other severe dysfunctional behaviors.

☐ Repeated destructive behavior towards self, others, and/or property.

☐ Severe impairment of mobility with physical and/or mental inability to use adaptive equipment, such as walkers, crutches, wheelchairs, etc.

☐ Chronic and/or long-term disease or injury, impairing ability to work or attend school during the recuperative period of the disease or injury.

☐ Severe or profound intellectual disability as defined by confirmed I.Q. test scoring.

Additional Comments:

Were any of the above psychiatric diseases caused by substance abuse or the effects and dependence of such abuse? ☐ Yes ☐ No

Current Treatment Frequency and Description:

Additional services or coordination of care:

Has the dependent been hospitalized or institutionalized for any of the above diagnoses during the past two years? ☐ Yes ☐ No

If yes:

Name of the Hospital: _____ Dates: _____

Nature of care: (conditions treated, treatment provided, etc.)

What is the dependent's function ability related to:

Activities of daily living (independent, requires assistance for feeding/dressing/bathing/grooming, dependent):_____

_____

Task completion (reading/writing ability, single step tasks, complex tasks):_____

_____

Social Interaction (speaking to strangers, interacting with family, nonverbal):_____

In your professional opinion, do you consider this individual to be permanently and totally incapacitated and incapable of self-support (e.g. based on your diagnosis, will the individual always be dependent on someone else for support and maintenance and never capable of full-time student or self-support)?

☐ Yes ☐ No

If no, what date do you anticipate this individual will recover and be able to resume self-support?

I hereby certify the information provided in the physician questionnaire is correct to the best of my knowledge:

_____	_____	_____
Attending Physician's Signature:	Date:	Medical Board License #
_____	_____	_____
Printed Name	Telephone Number	Address

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