Oklahoma State & Education Employees Group Insurance Board
DISABLED DEPENDENT ASSESSMENT

EMPLOYER INFORMATION

Group Name: ____

EMPLOYEE INFORMATION (Please Print)

SSN or Member ID #: ________________________________

Employee's Name	**First Name**	**M. I.**	**Last Name**
Please Print			

Mailing Address ____

____

City **State** **Zip Code**

Home # (_____) ______________________ **Work # (_____)** ______________________ **Cell # (_____)** ______________________

DEPENDENT INFORMATION

Dependent's Name	**First Name**	**M. I.**	**Last Name**
Please Print			

Date of Birth ____________________

Relationship ☐ **Son** ☐ **Daughter** ☐ **Other** ____________________________________

Dependent Resides ☐ **In Home with Member** ☐ **In a Nursing Home** ☐ **In Separate Housing**
☐ **Other (Explain)** ____

Is this child unmarried and primarily supported by you? ☐ **Yes** ☐ **No**

Please check the appropriate box(es) for the coverage you want:

☐ **Health** ☐ **Dental** ☐ **Vision** **Dependent Life:** ☐ **Premier Option** ☐ **Standard Option** ☐ **Low Option**

AUTHORIZATION (Please read before signing)

I authorize release of any and all information necessary to complete the review to determine if the above dependent is eligible to enroll or continue on my insurance through the State and Education Employees Group Insurance Board. I understand that any fee charged for this information is my responsibility as the member requesting coverage and is not eligible for payment, reimbursement, or consideration by the State and Education Employees Group Insurance Board. It is further understood and agreed that failure to provide complete and accurate information might affect my dependent's insurability and may constitute grounds for retroactive termination of coverage.

____ ____

Member's Signature **Date** **Dependent's Signature (If capable)** **Date**

Please Note: First time applicants must attach a copy of your most recent income tax return reflecting support of the dependent. If you are requesting extended coverage for currently covered dependents your form must be submitted at least 30 days prior to the dependent's 26th birthday.

ATTENDING PHYSICIAN MUST COMPLETE THIS SECTION

The information you provide about the limitations and abilities of this patient will determine if coverage is approved, denied, or continued under the member's policy. Please complete this section by checking all appropriate boxes. Any additional information can be provided on an attached sheet. Please note: Documentation must confirm the disability occurred before the patient reached age 26.

Condition is: ☐ **Mental** ☐ **Physical** **Condition Began** ____________________

Diagnosis ____________________ **ICD Code(s)** ____________________

Note: Diagnosis and current ICD codes must be completed in order for the assessment to be reviewed.

1. Mobility ☐ **Full** ☐ **Partial** ☐ **Total**

☐ **Specify** ____________________
(Bedridden, wheelchair, etc.)

2. Paralysis ☐ **None** ☐ **Partial** ☐ **Total**

☐ **Specify** ____________________
(Bedridden, wheelchair, etc.)

3. Mental ☐ **Irrational** ☐ **Confused** ☐ **Impulsive** ☐ **Hallucinating** ☐ **Delusional**

☐ **Aggressive** ☐ **Fearful** ☐ **Withdrawn** ☐ **Suicidal** ☐ **Homicidal**

☐ **Others – Please List** ____________________

____

4. Medical ☐ **Seizures** ☐ **Tremors** ☐ **Epilepsy** ☐ **Frailty** ☐ **Swelling**

☐ **Labored Breathing** ☐ **Cardiovascular Disease** ☐ **Respiratory Disease**

☐ **Others – Please List** ____________________

____

5. Prognosis ☐ **Excellent** ☐ **Good** ☐ **Poor** ☐ **Terminal**

6. Please list any special needs of this patient: ____________________

____

7. Please check the box which best applies to this patient:

☐ **Patient is unable to live independently and is not capable of self-support.**

Provide details: ____________________

____

☐ **Patient is able to live independently with monitoring and is capable of self-support.**

____________________ ____________________
Signature of Attending Physician **Date**

Return completed form to:
Oklahoma State and Education Employees Group Insurance Board
Health Care Management Division
PO Box 57830
Oklahoma City, Oklahoma 73157-7830