

**Office of Management and Enterprise Services
Employees Group Insurance Division
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 _____ SSN _____

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 Office of Management Enterprises (OMES) Employees Group Insurance Division (EGID). 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 EGID. 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:
Employees Group Insurance Division
Health Care Management Unit
PO Box 57830
Oklahoma City, Oklahoma 73157-7830