Request to Renew Health Coverage | Disabled Dependents

Please mail this completed form to:
Memorial Hermann Health Plan
Eligibility Department
929 Gessner Rd, Suite 1500
Houston, TX 77024
713.338.4683

MHHP maintains the information provided to manage your benefits. If you have questions about your information, or believe that information provided may be incorrect, please notify MHHP.

PART I: EMPLOYEE/RETIREE STATEMENT SECTION

A: PERSONAL DATA

Employee/Retiree Name: First, MI, Last	Last 4 digits of SSN	Agency Number
	xxx-xx-	

Mailing Address	City	State	ZIP Code

Phone Number Home ( ) Work ( ) Mobile ( )

Legal Name of Dependent: First, MI, Last	Dependent SSN	Dependent Date of Birth	Tobacco User
			○ Yes ○ No

Dependent Relationship*	Mailing Address	City	State	ZIP Code
○ daughter ○ son ○ other				

*Relationship: Select 'daughter' or 'son' for natural or adopted daughter or son.
Select 'other' for all others, including: stepchild, foster child, ward or child under managing conservator.

SECTION B: COVERAGE INFORMATION

You may submit this application to MHHP either: within 90 days before the date your covered dependent turns age 26, within 90 days before the expiration date of your child's disabled dependent coverage, during your Initial Enrollment Period as a new employee, during your Annual Enrollment period or within the first 30 days from the date of your dependent child's first medical treatment related to his or her disability.

Please note: A medical diagnosis of a permanent disability is not the only requirement a dependent must meet to gain coverage under this program. For example, the dependent must also be financially dependent on the employee/retiree and without a self-sustaining employment.

Dependent Coverage Requested:		Cancelled Date (if applicable)
○ Medical	Other: ○ Dependent Life ○ Employee and Family AD&D ○ Dental ○ Vision	

SECTION C: EMPLOYEE/RETIREE STATEMENT

1. Is the dependent mentally or physically disabled to the extent that he/she regularly depends on you for care or support? ○ Yes ○ No
   If yes, what percentage of care or support do you provide?_____%
2. Did you claim the dependent on your last Federal Income Tax Return? ○ Yes ○ No
   a. If yes, provide a copy of your last Federal Income Tax Return.
   b. If no, will you claim the dependent on your next Federal Income Tax Return? ○ Yes ○ No
3. Does the dependent share a primary residence with you? ○ Yes ○ No
   If no, please list the dependent's primary residence:_____
4. Does the dependent receive Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) or other disability benefits?
   ○ Yes ○ No If yes, provide copy of award letter and most recent monthly statement.
5. Is the dependent covered by Medicaid? ○ Yes ○ No or Medicare? ○ Yes ○ No
6. If applicable, please provide the following: Medicare Number: Part A Effective Date:
   Part B Effective Date: Medicaid Number: Effective Date:
7. If the dependent has ever been under observation, care or treatment in any hospital, sanitarium or similar institution as an inpatient, please complete the following: Name of hospital(s) or institution(s): _____
   Date of last treatment of care:_____Number of days _____
8. Nature of the dependent's disability: _____
9. Does this disability prevent the dependent from being able to work and support him/herself? ○ Yes ○ No
10. Date of first medical treatment relating to the disability: _
11. Is your dependent currently employed or previously employed within the last six months? ○ Yes ○ No
    If yes, provide a copy of your dependent's most recent W2 and/or 1099 and complete the information below.
    Employer: _____
    Job Duties:_____
    Dates Employed:_____Earnings: _____

SECTION D: CERTIFICATION

I certify that the above named disabled dependent lives with me or his/her care is provided by me, and I am responsible for his/her care or support. I also certify that the statements made above are true and complete to the best of my knowledge. I hereby authorize any hospital or physician who has treated this dependent, to furnish any medical information requested. I understand that continued coverage for this disabled dependent at the age of 26 and over is not guaranteed and is subject to approval by the Memorial Hermann Health Plan. I understand that any fraudulent statements may be cause for my permanent expulsion from Memorial Hermann Health Plan.

I understand and acknowledge that this form is a Legal Record and it is a criminal offense if I make any false statement in this Application on Request Continuation Of Coverage for a Disabled Dependent Child, at age 26 and Over in an attempt to defraud MHHP or any other person.

All of the information provided in this Application to Request Coverage for a Disabled Dependent Child at Age 26 and over, is true and correct and based on my personal knowledge.

Signature of Employee/Retiree	Date Signed (mm/dd/yyyy)	( ) Home Telephone No.	( ) Work Telephone No.
_____	____/____/_____	( ) _____	( ) _____

PART II: ATTENDING PHYSICIAN'S STATEMENT - *Any expense associated with the completion of this section will be the responsibility of the applicant. It is a crime to purposely misrepresent medical facts regarding the patient's condition.*

1. Is the dependent able to work at any occupation on a full-time basis? ○ Yes ○ No
   If no, was the dependent incapacitated from all work prior to reaching age 26 and when did the incapacity begin _____
2. Will the dependent be capable of employment in the future? ○ Yes ○ No ○ Questionable
   If yes or questionable, provide explanation and give approximate date and the type of employment (sedentary, light duty, etc.) the dependent will or may be capable of performing; including any limitations **or reasonable accommodations that may be required.**
   _____
3. Nature and extent of incapacity. Please provide a complete diagnosis, including an ICD-9 (International Classification of Diseases) notation. You may attach a narrative summary relative to the diagnosis/prognosis if needed:
   _____
   _____
4. Date dependent was last examined: Abnormal findings at the time of last examination:
   Prognosis:
5. How long has the patient been under your care?_____Provide the date the patient was first diagnosed with the disabling condition:
   _____
6. How does condition(s) restrict the dependent's ability to engage in normal activities of daily living?
   _____
   _____
7. Has this disability been diagnosed as permanent? ○ Yes ○ No If no, how long will condition last?
   _____
8. Physician Name (print):
9. Degree: Specialty Board Certification:
   (Physician must either be a medical doctor (MD) or doctor of osteopathic (DO) medicine.)
10. Physician Signature: Date:
    (Form is invalid without physician's signature and date of signature.)
11. Office Address:
12. Physician's Phone Number: Fax Number: _____

Health Plan Use Only:

○ Approved Re-Certification Date: ○ Denied

○ Additional Information Required

Underwriter/Counselor _____ Date ____/____/_____