HealthPartners

Disabled Dependent Application/Verification Form

Date: _____

Dependent's Name: _____ Dependent Member Number: _____

Policyholder's Name: _____ Policyholder's Member Number: _____

Policyholder's Address: _____

Employer Group Name: _____ Employer Group Number: _____

Application Number: _____ _____ (to be completed by underwriter)

Section A – To be completed by policyholder

Description of dependent's mental or physical disability: _____

_____

Date disability was diagnosed: _____ Age disability was diagnosed: _____

Does dependent reside full-time at your address? ☐ Yes ☐ No

If no, list dependent's current address: _____

Type of facility: _____

Percent of financial support provided by policyholder: ____% Dependent's age: ____

Dependent's date of birth: _____

Does dependent receive any type of financial support from any agency such as Social Security, Medicare/Medicaid or other federal, state or local agency? ☐ Yes ☐ No

If yes, how much is received per month from each source? _____

Do you claim the dependent on your federal tax return? ☐ Yes ☐ No

Is the dependent employed? ☐ Yes ☐ No

If yes, please complete: Name of employer: _____

Special needs arrangement? ☐ Yes ☐ No

If yes, please describe: _____

_____

Number of hours per week: _____ Income: _____ Job duties: _____

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Is the dependent eligible to receive medical benefits through this employer? ☐ Yes ☐ No

If no, why not: _____

Does the dependent maintain a driver's license? ☐ Yes ☐ No

If no, please provide the reason dependent is not able to drive:

_____

If your dependent is seen at a clinic other than a HealthPartners Clinic, providing copies of medical records with this form may assist in determining dependent eligibility.

Policyholder's signature: _____ *Date:* _____

Section B: To be completed by physician or medical professional

Diagnosis and history of dependent's mental or physical disability:

_____

_____

Date disability was first diagnosed: _____

Date of first treatment: _____ Date of last treatment: _____

Current treatment plan: _____

Is this individual currently capable of self-sustaining employment? ☐ Yes ☐ No

If no, what are the limitations that prevent this individual from self-sustaining employment?

_____

Do you expect this condition to be temporary or permanent: ☐ Temporary ☐ Permanent

What are this individual's future capabilities for self-sustaining employment?

_____

_____

Physician's signature: _____ *Date:* _____

Print physician's name: _____ *Phone number:* _____

Clinic name and address: _____

Please fax this completed form to 952-883-5070 or mail to HealthPartners, Mail Stop 21105H, PO Box 1309, Minneapolis, MN 55440-8725.