Disabled Dependent Application

(Attach Employee Benefit Enrollment Form)

Security Alert: Do not send this form via E-mail

Employee Name (Last, First) Please print | Social Security Number | Banner ID | Date of Birth

Street Address | City | State | Zip

Phone

Disabled Dependent Child Information

Name (Last, First) Please print | Social Security Number | Sex (Male/Female) | Date of Birth

Street Address | City | State | Zip

Relationship

Is dependent receiving Supplemental Security Income (SSI) or Social Security Disability benefits?

☐ Yes ☐ No

1. I understand under Michigan Public Act 275 of 1966, I may enroll my dependent for coverage as a dependent child who is incapable of self-sustaining employment because of a physical or mental disability which occurred before she/ he attained the age of 19. I have supplied certification of this disability from a physician licensed in Michigan by having the physician complete this form.
2. I understand my disabled child must be unmarried, legally reside with me, and depend on me for support and maintenance to qualify under Public Act 275. I have supplied certification of this dependency by attaching a copy of my last federal tax return.
3. I agree to furnish proof of my dependent's continued eligibility whenever required by my insurance carrier or Wayne State University.
4. I understand coverage begins on the effective date determined by Wayne State University.
5. I understand I must notify the HR Service Center of changes in my status and that of my family members which may affect coverage.
6. I understand when the insurance carrier accepts my application, I and my family are bound by all conditions of my medical insurance carrier.
7. I authorize my medical insurance carrier to obtain from providers of service, any and all records and information relating to me and my family members.
8. I am applying for coverage for the above named dependent. I understand and agree to the terms and conditions. I authorize the release of the information listed above to the insurance plan I have selected for the purpose of obtaining coverage. The information will be provided to the insurance plan in electronic format.

Employee Signature | Date

Physicians Certification

Diagnosis

Type of Disability

Prognosis for improvement so as to enable self-sustaining employment:

Date First Diagnosed

Physician's Address | Physician's Phone

Physician's Signature | Date

Please return to: HR Service Center, 5700 Cass Ave., Suite 3638, Detroit, MI 48202; Fax: 313-577-0637