PEBA
SC Retirement Systems and State Health Plan

South Carolina Public Employee Benefit Authority
Serving those who serve South Carolina

Incapacitated Child Certification

Section A (subscriber must complete this section and the shaded areas in Section B)

Subscriber's name	Subscriber's BIN or last four digits of SSN
Telephone number	☐ Active employee ☐ COBRA ☐ Retiree ☐ Survivor
Address	
Dependent's name	Dependent's date of birth

Is this dependent covered by any other health benefits, including Medicare/Medicaid? ☐ Yes ☐ No
If yes:
Name of the other insurance carrier: _____
Effective date of other coverage: _____ Policy number of other coverage: _____
Has the dependent applied for Social Security income? ☐ Yes ☐ No *If yes, indicate date:* _____

Are you, the subscriber, more than 50 percent financially responsible for the dependent? ☐ Yes ☐ No
If yes, attach a copy of your latest tax return or other supporting financial documentation.

When did the dependent's incapacitation (or medically necessary leave of absence) begin? _____
Is the dependent married? ☐ Yes ☐ No
Has the dependent ever been married? ☐ Yes ☐ No
Is the dependent living with you? ☐ Yes ☐ No
If no, where does the dependent reside? _____

Has the dependent ever been employed? ☐ Yes ☐ No
If yes:
Time period of current/latest employment: _____
Place of employment: _____ Number of hours worked weekly: _____
Job description: _____

I hereby certify that, to the best of my knowledge, all information provided is correct and that this dependent is incapable of self-support and remains dependent on me for support and maintenance. I understand that it is my responsibility to notify PEBA within 31 days of any change in this dependent's eligibility as defined in the *Insurance Benefits Guide* and that Standard Insurance Company and PEBA may review the status as necessary to verify continued eligibility. I acknowledge that failure to notify PEBA of changes in eligibility may result in penalties and recovery of benefits paid on behalf of the ineligible dependent.

Subscriber signature: _____ Date: _____

I hereby authorize Standard Insurance Company and PEBA personnel to contact healthcare providers, to request claims history and to confirm student-status history while determining this dependent's incapacity and eligibility for benefits. I also understand that I may be required to provide more information for determining this dependent's incapacity. I also understand that all information provided will be considered in determining this dependent's incapacity.

Subscriber signature: _____ Date: _____

Instructions

This information is required to verify incapacity for an eligible dependent child. Incapacity must be established before:

- Age 19 or while a covered and eligible full-time student (within 31 days of loss of full-time student status) for Dependent Life-Child insurance coverage; or
- Age 26 for all other coverage through PEBA.

Attach a letter from the educational institution the child was attending, if any, to verify eligibility at the time of incapacitation. The letter should include the date of withdrawal or loss of full-time student status and the dates of attendance.

Attach a completed *Authorized Representative Form* (Form 7213) signed by the incapacitated child, or other documentation that verifies your authority to act on behalf of the child (e.g., guardianship papers or power of attorney). The physician may request to see the *Authorized Representative Form* before completing Section B of this form. The *Authorized Representative Form* is available on our website, www.peba.sc.gov.

Section B (subscriber should complete shaded areas; dependent's physician must complete remaining areas)

Please return this completed section to the subscriber who gave it to you.

Dependent's name	Dependent's date of birth
Date incapacitation began	Date you last examined the dependent

Diagnosis and description of the incapacitation: ☐ Physical ☐ Psychiatric ☐ Both *(Select one and explain)*

_____

_____

_____

_____

If the diagnosis is mental illness, intellectual or physical disability, please provide the mental age or IQ:_____

If the diagnosis is psychiatric, complete the following.
Complete DSM-IV diagnosis required with descriptors, codes and severity specifiers:

Axis I:_____
Axis II:_____
Axis III:_____
Axis IV:_____
Axis V: Current:_____ Highest in the last year:_____

Current treatment frequency and description:

_____

_____

_____

Additional services or coordination of care:

_____

_____

_____

Has the dependent been hospitalized or institutionalized for any of the above diagnoses during the past two years? ☐ Yes ☐ No
If yes:

Name of the hospital/institution: _____
Dates of confinement: _____
Nature of care (conditions treated, treatment provided, etc.): _____

_____

_____

What is the nature and degree of the dependent's impairment in relation to the capacities for:

Daily activities: _____

_____

_____

Task performances: _____

_____

_____

Social interaction:_____

_____

_____

Section B continued

Dependent's name	Dependent's date of birth

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In your professional opinion, do you consider this individual to be permanently and totally incapacitated and incapable of self-support (e.g., based on your diagnosis, will the individual always be dependent on someone else for support and maintenance and never capable of full-time student status or self-support)?

☐ Yes ☐ No

In your professional opinion, do you consider this individual to be temporarily incapacitated and temporarily incapable of self-support?

☐ Yes ☐ No

If yes, what date do you anticipate this individual will recover and be able to resume self support? _____

Is the dependent fully compliant with treatment? ☐ Yes ☐ No

If no, would the prognosis be different if the dependent were compliant? Explain. _____

_____

_____

_____

I hereby certify that all information provided in Section B is correct to the best of my knowledge.

_____	_____	_____
Attending physician's signature	Date	Medical Board license #
_____	_____	
Print attending physician's name	Physician's telephone number	

Attending physician's address:

_____

_____

_____

_____

When submitting this form:

- Attach a letter from the educational institution the child was attending, if any, to verify eligibility at the time of incapacitation. The letter should include the date of withdrawal or loss of full-time student status and the dates of attendance.
- Attach a completed *Authorized Representative Form* (Form 7213) signed by the incapacitated child, or other documentation that verifies your authority to act on behalf of the child (e.g., guardianship papers or power of attorney). The physician may request to see the *Authorized Representative Form* before completing Section B of this form. The *Authorized Representative Form* is available on our website, www.peba.sc.gov.