

## 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:
Phone number:	<input type="checkbox"/> Active employee <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Survivor
Address:	Dependent's name:  Dependent's date of birth:
Is this dependent covered by any other health benefits, including Medicare/Medicaid? <input type="checkbox"/> No <input type="checkbox"/> Yes 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? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, date: _____	
Are you, the subscriber, more than 50 percent financially responsible for the dependent? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If Yes, please attach a copy of your latest tax return or other supporting financial documentation.</b>	
When did the dependent's incapacitation (or medically necessary leave of absence) begin? _____ Is the dependent married? <input type="checkbox"/> No <input type="checkbox"/> Yes                      Is the dependent living with you? <input type="checkbox"/> No <input type="checkbox"/> Yes Has the dependent ever been married? <input type="checkbox"/> No <input type="checkbox"/> Yes                      If No, where does the dependent reside? _____ Has the dependent ever been employed? <input type="checkbox"/> No <input type="checkbox"/> Yes 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 full-time student status and 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 <i>Insurance Benefits Guide</i> 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's Signature _____ Date _____	
<b>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.</b>	
Subscriber's 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 coverage **or**
- Age 26 for all other coverage through PEBA.

Please **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.

Please **attach a completed [Authorized Representative form](#)**, 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 at [www.peba.sc.gov](http://www.peba.sc.gov).

**SECTION B (subscriber should complete the shaded areas; dependent's physician must complete the rest)**

Dependent's Name:	Dependent's Date of Birth:
Date incapacitation began:	Date you last examined dependent:
Diagnosis and description of the incapacitation: <b>Physical</b> <b>Psychiatric</b> <b>Both</b> (circle one and then explain) _____ _____ _____	
If the diagnosis is mental retardation, please provide the mental age or IQ: _____	
If the diagnosis is psychiatric, please 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? <input type="checkbox"/> No <input type="checkbox"/> Yes 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: _____ _____	

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

**SECTION B (continued)**

Dependent's Name:	Dependent's Date of Birth:	
<b>Incapacitated Child Certification</b>	In your professional opinion, do you consider this individual to be <i>permanently and totally incapacitated</i> and incapable of full-time student status 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)? <input type="checkbox"/> No <input type="checkbox"/> Yes	
	In your professional opinion, do you consider this individual to be <i>temporarily incapacitated</i> and temporarily incapable of full-time student status and temporarily incapable of self-support? <input type="checkbox"/> No <input type="checkbox"/> Yes	
	If Yes, what date do you anticipate this individual will recover and be able to return as a full-time student or seek employment? _____	
	Is the dependent fully compliant with treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes  If <i>No</i> , 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.		
_____ <b>Attending Physician's Signature</b>	_____ <b>Date</b>	_____ <b>Medical Board License #</b>
_____ <b>Print Attending Physician's Name</b>	_____ <b>Physician's Telephone Number</b>	
Attending Physician's Address: _____ _____ _____		

**When submitting this form:**

- Please **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.
- Please **attach a completed [Authorized Representative Form](#)**, 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 at [www.peba.sc.gov](http://www.peba.sc.gov).