UNIVERSITY OF CALIFORNIA

Affidavit of Overage Disabled Child Eligibility
for UC Health & Welfare Benefits Plans

Instructions: To document and verify a disabled dependents' relationship to the plan subscriber (employee/retiree), this affidavit must be submitted to UC's Family Member Eligibility Verification (FMEV) vendor. The signature of a physician who can attest that the dependent qualifies as an overage disabled child is required. Along with this affidavit, the plan subscriber must submit other required documents as outlined in the FMEV packet to UC's Family Member Eligibility Verification vendor.

- DO NOT send information copied directly from the patient's medical record.
- Ensure parts A, B, C and D are completed and signed before submission.
- **If the physician selects NO in part C, this indicates your dependent is NOT eligible for UC Health and Welfare benefits. If NO is selected, do not submit this form.**

An eligible overage disabled child is defined as someone who is:

- 26 or older
- Unmarried
- Incapable of self-support due to a mental or physical disability
- Chiefly dependent on the Employee/Retiree or Spouse/Domestic Partner for support (50% or more)
- Claimed as the Employee's, Retiree's, Spouse or Domestic Partner's dependent for income tax purposes, or if not claimed as such dependent for income tax purposes, is eligible for Social Security income or Supplemental Security Income (SSI) as a disabled person or is working in supported employment which may offset the Social Security or SSI.

PART A: Plan Member (Employee/Retiree) and Dependent Information

Member Name: Last, First, MI:_____

Employee ID:_____ UC Location:_____

Overage Disabled Child Name: Last, First, MI:_____ Date of Birth:_____

PART B: Overage Disabled Child Authorization

The overage disabled child, or person authorized to act on their behalf, is to complete the information requested in PART B prior to giving the form to the physician for completion:

I hereby authorize my attending physician,_____, to furnish facts concerning my disability. I agree that a photocopy of this authorization shall be as valid as an original. I understand that if I do not sign this authorization, or if I revoke or modify it, UC Health & Welfare benefits may not be able to determine my eligibility as an overage disabled child and that my request may be denied. I also understand that UC Health & Welfare benefits will keep confidential the information which is provided pursuant to this authorization, and that it will be used solely to determine and act upon my request for this benefit.

_____ _____

Signature of Overage Disabled Child **OR** Date

_____ _____

Person authorized to act on their behalf Relationship to the overage disabled Child

PART C: Physician to Complete

Dear Doctor:
The patient requests you to complete this medical certification of disability and incapacity of self-support**.** It will assist UC Health & Welfare benefits in processing their claim for health insurance as a disabled child under their parent's health plan. By providing the medical information promptly, you will help the patient expedite the claims process. Please return the form to the patient upon completion. For purposes of this benefit, a UC Health & Welfare benefits member can retain their eligibility for health benefits as a family member if they are unmarried and incapable of self-support (i.e. not capable of engaging in any substantial gainful activity) due to physical or mental disability which existed continuously prior to becoming 26 years of age.

Based upon your medical or psychiatric opinion, does the patient currently have a physically or mentally disabling injury, illness, or condition?

- ☐ YES, the patient's current disability is of a permanent or extended duration and, consequently, the patient is not and will not be capable of self-support within the foreseeable future.
- ☐ NO, the patient does NOT have a physically or mentally disabling injury, illness or condition.

I certify that, based upon my examination of the patient, the above statements truly describe the patient's disability and their capability of self-support.

Physician's Signature **Date**

PRINT, TYPE or STAMP PHYSICIAN'S NAME AS SHOWN ON LICENSE and THEIR ADDRESS, TELEPHONE AND FAX NUMBERS:

PHYSICIAN'S NAME AS SHOWN ON LICENSE

ORIGINAL SIGNATURE OF ATTENDING PHYSICIAN

LOCAL ADDRESS

STATE LICENSE NUMBER

CITY, STATE ZIP

PHONE NUMBER

DATE

FAX NUMBER

PART D: Subscriber Signature and Date

By signing this affidavit, I attest that I have reviewed The Regents of the University of California Definitions of Dependents and Documentation Required and that the information I am submitting is true and accurate. I understand that providing false or misleading information may result in termination of coverage for my family members for up to 12 months per The Regents of the University of California Group Insurance Regulations (GIR), as well as charges to recover paid premium costs, costs of services from UC's carriers, and/or disciplinary action.

Subscriber Signature **Date**

Complete and return affidavit to UnifyHR via one of the following methods:

Website: app.unifyhr.com **Fax**: 1-469-844-3240 **Mail**: UnifyHR, P.O. Box 2785, Fargo, ND 58108