Northern Light Beacon Health Employee Health Plan

DISABLED DEPENDENT CERTIFICATION FORM

The purpose of this Disabled Dependent Certification Form is to verify eligibility of proposed new or existing Disabled Dependents (age 26 years or older, excluding spouses) for healthcare coverage offered by our Northern Light Employee Health Plan. If your Dependent is disabled, Beacon Health will regularly request verification that he or she remains eligible for coverage. In most cases you will be required to submit this form annually unless your Dependent's disability has been deemed permanent.

The Subscriber must complete Sections A, B, C and E. It is necessary for the family member's Primary Care Provider to complete Section D.

First Time Applicants:

- Please complete this Disabled Dependent Certification Form on behalf of any named Disabled Dependents (age 26 years or older, excluding spouses) who you have listed on your application for healthcare coverage under the Certificate.
- If you have questions regarding completion of this form, please call 1-855-429-1023.
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Current Subscribers:

- Please complete this form within 31 days of the date of its receipt.
- Please note that if we do not receive this completed form, along with any applicable documentation, within this timeframe, your family member's coverage will be terminated. Your family member may also be eligible for continued coverage under the Consolidated Omnibus Reconciliation Act (COBRA) or Mini-COBRA, as applicable. You will need to contact Northern Light Total Compensation to determine if this is an option.
- If you are a Plan Member and have eligibility questions, please contact 1-855-429-1023.

* **Please return completed form to: Beacon Health, Attention Northern Light Employee Health Plan, PO Box 202316, Austin, TX 78720**
Or Fax: 1-877-403-7162

* Northern Light Employee Health Plan is administered by Beacon Health

Northern Light Beacon Health

Employee Health Plan

(PLEASE PRINT)

SECTION A. SUBSCRIBERINFORMATION (To be completed by Subscriber)

1. LEGAL NAME (LAST)	2.. (MAIDEN NAME)	3. (FIRST)	4.(M.1.)

5. ADDRESS (NUMBER) (STREET)	(APT. NO.)	6. (CITY)	7. (STATE)	8. (ZIP)

9. SOCIAL SECURITY NUMBER	10. Date of Birth	11. GROUP NUMBER	12. INSURANCE ID NUMBER

SECTION B. DEPENDENT INFORMATION (To be completed by Subscriber)

If you have more than four (4) Dependents covered under this Certificate, please complate a separate Dependent Certification Form;

DEPENDENT #1*

LEGAL NAME	5. SOCIAL SECURITY NUMBER	6. DATE OF BIRTH MONTH DAY YEAR	7. Northern Light Medical Record Number (if any)	8.MARITAL STATUS	9. DATE OF MARRIAGE Month Day Year
1. FIRST 2. MI 3. LAST 4 MIDDLE NAME				D SINGLE D MARRIED	

o Relationship of Dependent to Subscriber: O Son O Daughter O Other Legal Relationship

o Dependent is chiefly (more than 50%) dependent on Subscriber for support and maintenance: O YES O NO

DEPENDENT #2*

LEGAL NAME	5. SOCIAL SECURITY NUMBER	6. DATE OF BIRTH MONTH DAY YEAR	7. Northern Light Medical Record Number (if any)	8. MARITAL Status	9. DATE OF MARRIAGE Month Day Year
1. FIRST 2. MI 3. LAST 4 MIDDLE NAME				D SINGLE O Married	

10. Relationship of Dependent to Subscriber: O Son O Daughter O Other Legal Relationship

o Dependent is chiefly (more than 50%) dependent on Subscriber for support and maintenance: O YES O NO

DEPENDENT #3*

LEGAL NAME	5. SOCIAL SECURITY NUMBER	6. DATE OF BIRTH MONTH DAY YEAR	7. EMHS Medical Record Number (if any)	8. MARITAL STATUS	9. DATE OF MARRIAGE MONTH DAY YEAR
1. FIRST 2. MI 3. LAST 4 MIDDLE NAME				D SINGLE D MARRIED	

10. Relationship of Dependent to Subscriber: O Son O Daughter O Other Legal Relationship

11. Dependent is chiefly (more than 50%) dependent on Subscriber for support and maintenance: O YES O NO

DEPENDENT #4*

LEGAL NAME	5. SOCIAL SECURITY NUMBER	6. DATE OF BIRTH MONTH DAY YEAR	7. Northern Light Medical Record Number (if any)	8. MARITAL STATUS	9. DATE OF MARRIAGE MONTH DAY YEAR
1. FIRST 2. MI 3. LAST 4 MIDDLE NAME				D SINGLE D MARRIED	

10. Relationship of Dependent to Subscriber: O Son O Daughter O Other Legal Relationship

11. Dependent is chiefly (more than 50%) dependent on Subscriber for support and maintenance: O YES O NO

***PLEASE NOTE:** IF ANY ABOVE NAMED DEPENDENT LIVES WITH A CUSTODIAL PARENT, PLEASE IDENTIFY THE APPLICABLE DEPENDENT AND PROVIDE THE NAME AND ADDRESS OF THE CUSTODIAL PARENT IN THE SPACE BELOW.

Northern Light Beacon Health

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SECTIONC. EXISTING HEALTH COVERAGE (To be completed by Subscriber)

1. While covered under this Certificate, will you or any Dependent(s) listed on this application also be covered by Medicare? O Yes O No
   If you answered "Yes" to question 1, provide the following information for each person, as applicable:

Name of Person(s}:	Medicare#	Part A or Part B	Effective Date

2. Are you or any Dependent(s) listed on this application currently receiving Disability/Worker's Compensation Benefits? O Yes O No
   If you answered "Yes" to question 2, provide name of person(s) and condition: _____

3. While covered under this Certificate, will you or any Dependent(s) listed on this application also be covered by other health insurance? O Yes ONo If you answered "Yes" to question 3, complete A through G below:

A. NAME OF INSURANCE COMPANY	B. SUBSCRIBER NAME	C. TYPE OF PLAN D **FAMILY** PLAN D SELF ONLY
D. EFFECTIVE DATE OF COVERAGE	E. INSURANCE I.D. NO. OR SOCIAL SECURITY NO.	F. GROUP NAME (EMPLOYER) / G. GROUP NUMBER

SECTION D. DISABLED DEPENDENT CERTIFICATION (To be completed by Provider)

Are any Dependents identified in this questionnaire incapable of self-sustaining employment by reason of disability resulting from mental retardation or physical disability which meet the criteria under 40 P.S. Section 752(A)(9) and Title 31, Pa Code, Section 88.41 AND who became so prior to the attainment of age nineteen (19)?
0 YES **O** NO

DEPENDENT #1 Name: _____

Explanation of disabilities _____

Do you consider this disability to be a permanent/lifetime disability? O Yes O No

(Name of Primary Care Provider)	(Provider's Signature)	(Date)	(Address of Provider)

DEPENDENT #2 Name: _____

Explanation of disabilities _____

Do you consider this disability to be a permanent/lifetime disability? O Yes O No

(Name of Primary Care Provider)	(Provider's Signature)	(Date)	(Address of Provider)

SECTION D. DISABLED DEPENDENT CERTIFICATION (To be completed by Provider)

Are any Dependents identified in this questionnaire incapable of self-sustaining employment by reason of disability resulting from mental retardation or physical disability which meet the criteria under 40 P.S. Section 752(A)(9) and Title 31, Pa Code, Section 88.41 AND who became so prior to the attainment of age nineteen (19)?

0 YES O NO

DEPENDENT #3 Name: _____

Explanation of disabilities _____

Do you consider this disability to be a permanent/lifetime disability? O Yes O No

_____ _____ _____ _____

(Name of Primary Care Provider) (Provider's Signature) (Date) (Address of Provider)

DEPENDENT #4 Name: _____

Explanation of disabilities _____

Do you consider this disability to be a permanent/lifetime disability? O Yes O No

_____ _____ _____ _____

(Name of Primary Care Provider) (Provider's Signature) (Date) (Address of Provider)

FOR OFFICE USE ONLY

O APPROVED for Dependent O **#1** O #2 O #3 O #4 O DISAPPROVED for Dependent O **#1** O **#2** O **#3** O **#4**

Name SIGNATURE Effective Date

SECTION E. DECLARATION OF SUBSCRIBER

The information recorded above is true and correct to the best of my knowledge and belief.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

_____ _____

Signature of Applicant/Subscriber Date Signed