CERTIFICATION OF ADULT DEPENDENT FORM

Subscriber Statement:
This form is to notify you that according to our records your dependent will soon exceed the age limit for being a covered dependent. You will no longer be able to continue this dependent covered unless they meet the requirements set forth in your Summary Plan Document of a disabled handicapped dependent, which is incapable of self-sustaining employment by reason of mental or physical incapacity. To continue coverage under the Plan, certification of adult dependency must be completed by the subscriber and the attending physician at the Plan's discretion. This form must be completed prior to the child turning 26 in order to continue coverage.

EMPLOYEE NAME: ____

MEMBER ID: ____

DEPENDENT NAME: ____

DEPENDENT DATE OF BIRTH: ____

Please check one of the below questions:

____ 1. The dependent no longer meets the requirements of a dependent as of ____________ and should be taken off the plan.

____2. The adult dependent qualifies under the description of a handicapped dependent, which is incapable of self-sustaining employment by reason of mental or physical incapacity, primarily dependent upon the covered Employee for support and maintenance and is unmarried.

a. Does the adult dependent currently reside in your household?
 · Yes · No
 If no, please explain: ____
 ____

b. Is the adult dependent claimed as a dependent on your federal income tax statement?
 · Yes · No
 If no, please explain: ____
 ____

c. Does the adult dependent rely on you for more than one-half of their financial support?
 · Yes · No
 If no, please explain: ____
 ____

The enclosed physician statement must be completed but the attending physician regarding the disability or impairment of the adult dependent. If the adult dependent is social security disabled, please furnish documentation from the Social Security office for verification.

Required Signature

Under penalty of perjury, we declare that the statements above are true and complete to the best of our knowledge. We further declare that we have read, understand, and agree to the terms and conditions on this form.

____

Subscriber Signature Date

Physician Statement:

Patient's Name: ____

Patient's Date of Birth: ____

The patient listed above has been diagnosed by me and is receiving medical treatment for the following condition(s):

____

____

The condition(s) listed above began (or was first diagnosed) on: ______________________________

List specific physical and/or mental restrictions: ____

____

____

Current plan of treatment: ____

____

____

In your professional opinion, does the disability prevent the patient from engaging in self-sustaining employment by reason of physical or mental handicap? ▪ Yes ▪ No

Comments: ____

____

In your professional opinion, could the disability improve? ▪ Yes ▪ No

Comments: ____

____

____

Physicians name (please print)

____

Office address

____

Physician's phone number

____

Physician's Signature Date

Please return the **Subscriber Statement** and the **Physician Statement**, along with all relevant medical documentation, that supports the disability diagnosis to:

WebTPA, Inc.
PO Box 1808
Grapevine, TX 76099-1808
Attn: Eligibility Department

Questions, please call WebTPA at 855-346-LSU1