Disabled Dependent Certification Form

PO Box 1808
Grapevine, TX 76099-1808

TO BE COMPLETED BY THE SUBSCRIBER

Subscribers Statement	This form is used to certify that the dependent meets the definition of a handicapped child, as described in your summary plan document. This form must be completed as required after the initial determination of disability is made and prior to the dependent's 26th birthday.	
1. Subscriber's Name (Last, First, Middle Initial)		2. Employer Group Name
3. Dependent's Name (Last, First, Middle Initial)	4. Dependent's DOB	
a. Does the dependent currently reside in your household? Or in a facility under your care? ☐ Yes ☐ No		
b. Is dependent currently employed? ☐ Yes ☐ No	If yes, Date of Hire	If no, will/might they be in some point the future?
c. Is dependent listed as a dependent in your last Federal Personal Income Tax Return? ☐ Yes ☐ No		
d. Does the dependent rely on you for more than one-half of their financial support? ☐ Yes ☐ No		
e. Is the dependent married? ☐ Yes ☐ No	f. Does the dependent qualify for Social Security disability benefits?[1] ☐ Yes ☐ No	
I certify that the above information is correct and authorize the release of medical information requested with respect to this certification. Any fraudulent statements or knowingly omitting any pertinent information is considered deceptive and may result in legal consequences or penalties.		
Signature of Subscriber		Date Signed

The enclosed physician statement must also be completed and returned. This statement must be completed by the attending physician regarding the disability or impairment of the adult dependent.

[1]If the adult dependent is social security disabled, please furnish documentation from the Social Security office for verification.

Please complete and 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 800-758-2525.

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TO BE COMPLETED BY THE PHYSICIAN

Physician Statement	Please answer all questions below to the best of your ability. Any fraudulent statements or knowingly omitting any pertinent information is considered deceptive and may result in legal consequences or penalties.
1. Patient's Name (Last, First, Middle Initial)	2. Patient's DOB
3. Is the patient totally disabled? ☐ Yes ☐ No Please describe the disability:	
4. Does the patient's disability keep them from self-sustaining gainful employment? ☐ Yes ☐ No	
a. Date the patient was diagnosed with disability keeping them from self-sustaining gainful employment:	b. Was this disability present and diagnosed prior to the dependents 26th birthday? ☐ Yes ☐ No
5. Will or can the patient's disability improve? ☐ Yes ☐ No	a. If yes, when might the patient be capable of self-support?

____
Physician's name (please print)

____
Office address

____
Physician's phone number

I certify that the above information is correct and understand that any fraudulent statements or knowingly omitting any pertinent information is considered deceptive and may result in legal consequences or penalties.

____________________________________ ____________________
Signature of Physician Date Signed

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

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PO Box 1808
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