District School Board of Pasco County

Disabled Adult Dependent Certification Form

A separate form must be completed for each disabled dependent

This form is used to determine if your dependent child meets the eligibility requirements for continued coverage after reaching the age limit (26 years). You may be eligible to continue coverage for your disabled dependent(s) on your medical, dental or vision plans or newly enroll, if not previously eligible. To determine eligibility for coverage, this form must be submitted upon initial enrollment of a disabled dependent and annually thereafter, buy October 31st of each benefit plan year, for coverage beginning January 1st of the upcoming benefit plan year.

Please Print or Type:

Employee ID#_____ Employee Name_____
Last Name First Name MI

Disabled Adult Dependent Information

Name_____ Date of Birth: _____ SSN: _____
First Name MI Last Name MM/DD/YYYY

Address: _____

Relationship to Employee: ☐ Natural Child ☐ Adopted Child ☐ Foster Child ☐ Step Child ☐ Other: _____

I hereby certify that the above information is correct to the best of my knowledge and authorize the release of any information required for certification.

_____ _____
Employee's Signature (Must print to sign) **Date**

Disabled Adult Dependent Certification: (The dependent's treating physician must complete this section. The section must be dated and include the physician's name, signature and office stamp.)

1. Is the dependent incapable of self-sustaining support and reliant upon another (the employee listed above) for their support and maintenance due to disability? ☐ Yes ☐ No
2. Is the disable adult dependent able to provide 50% or more of support for themselves: ☐ Yes ☐ No
3. Dependent's age when disability occurred: _____
4. Diagnosis of Disability: _____
5. Estimated expected date of full or partial recovery: _____
6. Nature of disability: *Please provide a statement of substantiation to meet the criteria for Social Security's definition for disability.*

Physician Name: _____ Phone: _____
Physician Signature: _____ Address: _____
Date Signed: _____ _____

Send Completed Form to:	
Returned by Physician: Email mybenefits@pasco.k12.fl.us or Fax: (813) 794-2078	Returned by Employee: Upload the completed form to CBIZ.

Instructions on how to upload documents are available online at http://www.pasco.k12.fl.us/ebarm/page/dependent-verification