OPEH&W HealthPlan
www.opehw.com

Dependent Child with Disabilities

Member's SSN

Section A: Dependent Child Details

Last Name

Gender Male ◯ Female ◯

First Name

Middle Initial

Date of Birth MM/DD/CCYY

SSN

Relationship to Member

Mailing Address
(if **NOT** residing with member)

City, State & ZIP Code

Section B: Nature & Degree of Disability

(Explain as fully as possible, If you require additional space, please securely attach an additional page)

Section C: Primary Care Physician **(of your dependent)**

Physician's Name

Address

City, State & ZIP Code

Phone ___-___-____

Section D: Education & Training

Level of Education Completed

Number of Hours Attending Per Week (if currently enrolled)

Schools or Training Programs Currently Enrolled & Attending

Work Being Performed for Wages or Profit (Explain Work Performed, Number of Hours per Week Worked, and Amount of Monies Earned)

Does this Dependent Child Qualify as Your Dependent on Your Federal Income Tax Returns? Yes ◯ No ◯
(If Yes, Please Attach a Copy of Your Most Recent Federal Income Tax Return)

Section E: Member Acknowledgement

I hereby certify that I have completed this form correctly and that the above statements are true and complete. I understand that false or deceptive statements made on this form or in filing a claim for benefits under the Plan will result in termination of coverage and possible prosecution for fraudulent misrepresentation.

Member's Signature

Today's Date MM/DD/CCYY

Make sure your SSN number is at the top of this form, then return it to your employer's benefit coordinator