Statement of Dependence Application
For Coverage of a Disabled Dependent

Must be disabled prior to dependents 19th birthday

BY COMPLETING THIS FORM THE MEMBER IS REQUESTING COVERAGE BEYOND THE AGE COVERAGE WOULD OTHERWISE TERMINATE*, FOR A DEPENDENT CHILD WHO IS INCAPABLE OF SELF-SUSTAINING EMPLOYMENT DUE TO A DISABILITY, AND WHOLLY DEPENDS UPON THE COVERED MEMBER FOR SUPPORT. Please note that we will not be able to continue coverage for your son/daughter unless we receive, review and approve your paperwork at least 30 days before your son/daughter reach the normal age he/she would otherwise lose coverage.*

This Section to be Completed by Fund Member (Please Print or Type)

Member Name BF# Social Security Number (Last 4 digits)

XXX-XX-_____

Home Address (No. and Street) Apt# City State Zip

Dependent's Name Dependent's Date of Birth Gender

___ Male ___ Female

Dependent Relationship to Member

[ ] Son [ ] Daughter [ ] Other _____

Dependent Marital Status

[ ] Single [ ] Widowed [ ] Married [ ] Divorced

Date of Employee Benefits Unit Approval _____ **[ ] Papers attached**

Is this a New Application [ ] or a Renewal Application [ ]

If renewal application, please give date disability commenced _____

Does the dependent listed above permanently reside with you? [ ] Yes [ ] No

Has the dependent listed above ever been institutionalized? [ ] Yes [ ] No

If yes, give name and address of institution _____

_____

Period of Confinement (dates) _____

Was the dependent ever employed for wages? [ ] Yes [ ] No

Presently working/last worked at: _____

Date last worked: _____ Wages Paid: _____

Is the dependent receiving government benefits related to this disability (Social Security, Workers' Compensation, Medicare, etc.)? [ ] Yes [ ] No

If "Yes", how much and at what frequency? _____

If the dependent has been found eligible for Supplemental Security Income (SSI) or Social Security Disability insurance, <u>you must</u> provide documentation of same. (Example; Notice of Award letter)

Is this a work-related illness, accident or disabilty? [ ] Yes [ ] No

If "Yes", have you applied for Workers' Compensation? [ ] Yes [ ] No

Is the disability related to an automobile accident? [ ] Yes [ ] No

IMPORTANT: THIS FORM WILL NOT BE PROCESSED WITHOUT A PHYSICIAN'S SUMMARY OF THE DEPENDENT'S CONDITION. FAILURE TO SUBMIT THE REQUESTED DOCUMENTS MAY RESULT IN A DELAY, DENIAL OR TERMINATION OF COVERAGE FOR THE ABOVE-NAMED DEPENDENT. (see other side for details)

I certify that I have carefully and fully read the important information on the preceding page of this form. I also certify that the statements and answers given are complete and correct to the best of my knowledge and belief. I have provided supportive documentation on my dependent's disability as requested above and I am aware that without proper documentation coverage may be denied. I am also aware that additional information may be required to make a determination of coverage and that presenting this documentation does not imply automatic coverage.

I agree to promptly advise Suffolk County Employees Benefit Fund within 30 days of any change that affects my disabled dependent's eligibility, including change of address, securing full-time, self-sustaining employment or elimination of the previously existing disability. I understand that any person who knowingly and with intent to defraud Suffolk County Employee Benefit Fund, any insurance company or any person who files an application for insurance/health benefits 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 act, which may be a crime, and shall also be subject to a monetary responsibility for any claims paid on behalf of the otherwise ineligible individual.

Member Signature _____ Date _____

Your completed paperwork is required at least 30 days prior to your dependent reaching the coverage termination age.* Completed paperwork includes this form and physician's summary.

The PHYSICIAN'S SUMMARY must be on the physician's office stationery and signed by your dependent's doctor.
It must include:

- The specific nature of the condition;
- Signs and symptoms associated with the condition;
- The date such condition commenced;
- A recent evaluation (within six months) that demonstrates how your dependent's condition prevents any form of self-sustaining employment and that accommodation is not possible; and
- Physician's contact information including telephone and fax numbers – PRINTED CLEARLY.

If you have any questions, please do not hesitate to contact Wendy Z, the Eligibility Coordinator, at: 631-319-4099 ext. 321 or email at Wendyz@scmebf.org

***Age at which a dependent child would otherwise lose coverage: if your child becomes disabled prior to age 19, you must file this form prior to their 19th birthday. If your child is a full-time student and becomes disabled, you must file this form while they are a full-time student and prior to age 25 or before that dependent's coverage would otherwise be terminated in accordance with the eligibility rules in effect at the time the disability commenced (example; no longer a full time student, graduation, etc.)**

This Section To Be Completed by Suffolk County Municipal Employees Benefit Fund

Effective date of ancillary benefits for above dependent: _____

Was previous SOD submitted? [ ] Yes [ ] No

Was dependent a late enrollment? [ ] Yes [ ] No

I have reviewed the documentation submitted and verified that the dependent meets eligibility requirements of the Plan.

[ ] Permanently approved [ ] Temporarily approved to _____

Benefit Fund Administrator Signature _____ Date _____

SOD62519

SUFFOLK COUNTY MUNICIPAL EMPLOYEES BENEFIT FUND

STATEMENT OF DEPENDENCE APPLICATION/RENEWAL AFFIDAVIT
FOR COVERAGE OF A DISABLED DEPENDENT

STATE OF)
) ss.:
COUNTY OF)

_____, being duly sworn deposes and says, under
(name of covered member)

penalty of perjury:

That I understand that I will be required to continue to provide proof of said dependency status, on an annual basis, to the Fund. **I understand that the specific nature of the condition, signs and symptoms associated with the condition and the date such condition commenced; a recent evaluation (within six months) that demonstrates how your dependent's condition prevents any form of self-sustaining employment and that accommodation is not possible. Physician's contact information including telephone and fax number are required to be submitted. I further cerify that all statements are true and correct.**

DATED: _____, 20___ _____
(signature of covered member)

Sworn to before me this

____ day of _____, 20__. _____
(Notary Public)

My Commission Expires: _____

SUFFOLK COUNTY MUNICIPAL EMPLOYEES BENEFIT FUND

STATEMENT OF DEPENDENCE – MEDICALLY APPROVED - FOR DEPENDENT

In the matter of _____, _____,
(Dependent) (dependent social security number)

BF Member _____, _____, who
(name) (social security number)

is a member of the Benefit Fund and who resides at:

_____.
(member's complete address)

Criteria

Employee Statement of Dependence approval for a dependent are defined as following criteria:

1. Deemed disabled prior to dependents 19 birthday.
2. The dependent permanently resides with the member.
3. Incapable of self-sustaining employment due to a disability.
4. Dependent wholly depends upon the covered member for support.
5. The dependent is unmarried child, stepchild or adoptive child.

_____
Initials