Disability Statement for Overage Dependent Coverage

Dependents who would typically lose coverage after reaching age 26 may extend coverage if they have a disability that can be verified by a physician. This disability must be a physical or mental condition which prevents the dependent from maintaining self-sustaining employment, and causes the dependent to chiefly rely on the subscriber for support and maintenance. This statement must be filled out by the subscriber and physician, and sent to help@collectivehealth.com.

Subscriber Information

Full Name:___________________________

Member ID (or social security number):______________________

Date of Birth:_____________________

Dependent Information

Full Name:___________________________

Member ID (or social security number):______________________

Date of Birth:_____________________

I, the undersigned subscriber, certify that the dependent listed above is chiefly supported by me, and is unable to maintain self-sustaining employment due to the physical or mental disability stated below by my physician.

____

Subscriber's Signature *Date*

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**To be filled out by physician*

Physician Information

Full Name:_______________________________ Phone Number:_____________________

Practicing Address:____

License Number:______________________________

Dependent's Diagnoses:____
____
____

Dependent's Prognosis:____
____
____

Is the disability **permanent** or **temporary**? (Circle One) If temporary, what is the estimated time frame for the disability?____
____

I, the undersigned physician, certify that the dependent listed above has a disability which prevents him/her from maintaining self-sustaining employment, resulting from the diagnoses stated above. Furthermore, the prognosis listed above is my professional assessment of the future course of said diagnoses.

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Physician's Signature *Date*