SCMA MEMBERS' INSURANCE TRUST

Handicapped Dependent Child Application & Certification

Completing the Handicapped Dependent Child Application & Certification

Completion of this application and certification is required to enroll a Handicapped Dependent child. This applies to Dependent children that are coming upon age 26 and need benefits to continue due to a mental disability or physical handicap. To determine if your Dependent child qualifies for continued enrollment as a Dependent child, completion of this form by you **AND** your Dependent child's treating physician is **required**.

Instructions

1. **Employee Application Pages**: Section I, II, III, and IV to be completed in their entirety by employee. Employee is required to sign, date, and provide printed name in Section IV, Employee Confirmation, Signature and Date.

2. **Orders**. Employee must provide an active copy of any "order/s" (*guardianship, conservatorship, court order, divorce decree*) employee has in place for the Dependent if circled in Section II.

3. **SSDI Statement**. Employee must provide a current (within the last 3 months) copy of the SSDI/SSI Benefit Statement if "Yes" was circled in Section III, Question 4.

4. **Physician Certification.** The treating physician must complete in its entirety and sign and date. Please note: the certification form MUST be received by MIT within 3 months of the physician's dated signature.

5. **Copy**. Confirm all pages of the certification form have been completed in their entirety **AND** make a copy for your files before returning the form. (*Omission of any required information will cause a delay or inability to process your request*.)

6. **Return**. Return all pages of the fully completed certification form and any additional documents to MIT at the email address or fax number shown below.

   SCMA Members' Insurance Trust (MIT)
   Email: MITinfo@scmedical.org
   Fax: 803-731-4021

Following receipt of your application and certification, you will receive confirmation from MIT of the review determination. Please allow up to 30 business days for review completion, which begins from the date of receipt of all required documents.

For any additional questions regarding your Dependent child's eligibility for benefits, please contact MIT.

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Employee's Application — **Employee to complete Section I, II, III & IV. Omitted information will cause delays.**

Section I. Employee Information

Participating Employer Name:

PRINT Employee Name: (First, Middle, last)

Date of Birth (mm/dd/yyyy)	Relationship to Dependent	Phone:

Employee Current Address(es) (Street, City, State, Zip Code)

Physical:

Mailing:

Email:

Section II. Dependent Information — Refer to the MIT Summary Plan Description for who qualifies as an eligible Dependent

Circle all applicable orders in place designating Employee to act for Dependent. Guardianship Court Order
If circled, submit an active/current copy of each Conservatorship Divorce Decree

PRINT Dependent Name: (First, Middle, Last)	Date of Birth (mm/dd/yyyy)

Dependent Marital Status: Never Married Married Divorced Widowed Legally Separated

Does Dependent physically reside with you on a daily basis <u>at the same address</u>?	YES NO

If **NO**, provide reason for different residing address than employee. (Example: Lives in a group home, medical facility, etc.):

Reason:

Residence address:

Section III. Financial and Dependent Employment Information

1. Is Dependent over age 26? (Circle One)	YES NO
2. Complete 2a-2d to determine if you provide the majority of financial support & maintenance for the Dependent	
2a Do you pay for Dependent's portion of the housing where he/she resides?	Not Applicable YES NO
2b Do you pay for Dependent's monthly food expenses?	Not Applicable YES NO
2c Do you pay for Dependent's monthly prescriptions (out of pocket)?	Not Applicable YES NO

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Section III. Financial and Dependent Employment Information (Continued**)**			
2d Do you pay for Dependent's portion of the utilities (heat, light, water)		Not Applicable YES NO	
Please note, supporting documentation to the answers provided above in question may be requested			
3. Federal Personal Income Tax Return – What was the Last Tax Year you Claimed Dependent as a tax dependent?			
4. Does Dependent receive SSDI/SSI benefit?		YES NO	
4a If YES, amount per Month (submit a copy of current SSDI/SSI Benefit Statement)		$	
5. Is Dependent currently working?	Currently Not Working	Full-Time	Part-Time
5a If Dependent is NOT currently working, provide date last employed:		Date (mm/dd/yy)	
5b If Dependent is currently working, provide: gross monthly Income (before taxes):		$	
5c Provide name and address of Dependent's current employer below: (Street, City, State, Zip Code)			
5d Is Dependent's current position with his/her employer eligible for health insurance?		YES NO	
5e If answered YES, above in 5d, is Dependent carrying "own" health insurance?		YES NO	
5f If answered NO, above in 5e, provide explanation as to why Dependent is not carrying "own" coverage.			
6. Is Dependent currently a student in post-secondary schooling?		YES NO	
6a If YES, enrolled:		Full-Time Part-Time	
6b Grade/Level:			
6c School type:			
6d If NO, when was the last date attended?		Date (mm/dd/yy):	
6e If NO, what was the highest degree or grade level of schooling completed?			
7. Does Dependent hold a valid driver's license?		YES NO	
Provide any further explanations/additional information: (attach additional pages if needed)			

Section IV. Employee Confirmation, Signature and Date

I confirm that the foregoing answers are true and correct to the best of my knowledge and belief.

PRINT Employee Name: _____

Employee Signature: _____ Date: _____

For processing purposes, Employee's Application and the attached Physician Certification MUST be submitted together.

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THIS PAGE IS TO BE COMPLETED IN FULL BY THE DEPENDENT'S TREATING PHYSICIAN ONLY.

Physician Certification	(Any fee for the completion of this Certification is to be paid by the employee.) Answer all questions below. Omitted information will cause delays.

Patient's Name: (First, Middle, Last)	Patient's Date of Birth: (mm/dd/yyyy)

1. What is the Patient's primary disabling diagnosis?

2. Age Patient diagnosed with primary disabling diagnosis? (Circle One) From Birth / From _____ Years of Age

3. The Patient is presently: (Circle all applicable) Ambulatory Confined to: Bed House Hospital Wheelchair

4. What are the physical/mental/functional limitations related to Patient's primary disabling diagnosis?

5. Are there any other diagnoses currently being treat?	YES	NO
If YES, please list:		

6. Is Patient currently able to work?	YES	NO	6a If YES (circle one)	Full-time	Part-Time
7. Is Patient currently able to be "financially" self-supportive (does not need to depend on others for financial support)?				YES	NO
8. Is Patient currently physically able to care for self in all aspects of ADLs (activities of daily living)?				YES	NO

9. If answered NO in 7 or 8 above, please explain below:

Intellectual/Development Disability Physical Handicap Mental Handicap Other (Explain below)

10. Will Patient be capable of self-support in the future?	YES	NO
If YES, as of what date? Date (mm/dd/yy):		

☐ Check box if documents attached.

I hereby certify that the above-described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.

Physician Signature: _____ Date: _____

PRINT Physician Name, Address (Street, City, State, Zip Code)	Phone: (Including Area Code)

For processing purposes, Employee's Application and this Physician Certification MUST be submitted together.