Bay Bridge Administrators

Incapacitated Child Certification Form

This information is required to verify incapacity for an eligible dependent child. Incapacity must be established before Age 26.

SECTION A ***(TO BE COMPLETED BY POLICY HOLDER)***

Policy Holder's Name:	Policy Holder's SSN:
Phone Number:	❑ Active Employee ❑ COBRA ❑ Retiree ❑ Survivor
Address:	Dependent's Name: Dependent's Date of Birth (MM/DD/YYYY):

Are you, the Policy Holder, more than 50% financially responsible for the dependent? ❑ No ❑ Yes

When did the dependent's incapacitation (or medically necessary leave of absence) begin?_____

Is the dependent married? ❑ No ❑ Yes

Has the dependent ever been married? ❑ No ❑ Yes

Is the dependent living with you? ❑ No ❑ Yes

If *No*, where does the dependent reside?_____

I hereby certify that, to the best of my knowledge, all information provided is correct and that this dependent is incapable of self-support and remains dependent on me for support and maintenance. I understand that it is my responsibility to notify Bay Bridge Administrators within 31 days of any change in this dependent's eligibility and that Bay Bridge Administrators may review the status as necessary to verify continued eligibility. I acknowledge that failure to notify Bay Bridge Administrators of changes in eligibility may result in penalties and recovery of benefits paid on behalf of the ineligible dependent.

Policy Holder's Signature Date

_____ _____

I hereby authorize Bay Bridge Administrators personnel to contact healthcare providers, to request claims history while determining this dependent's incapacity and eligibility for benefits. I also understand that I may be required to provide more information for determining this dependent's incapacity. I also understand that all information provided will be considered in determining this dependent's incapacity.

Policy Holder's Signature Date

_____ _____

Please see Page 2 for the Attending Physician's Statement.

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SECTION B ***(TO BE COMPLETED BY DEPENDENT'S PHYSICIAN)***

Dependent's Name:	Dependent's Date of Birth:

Incapacitated Child Certification

In your professional opinion, do you consider this individual to be *permanently and totally incapacitated* and incapable of full-time student status and incapable of self-support (e.g., based on your diagnosis, will the individual always be dependent on someone else for support and maintenance and never capable of full-time student status or self-support)? ❑ No ❑ Yes

In your professional opinion, do you consider this individual to be *temporarily incapacitated* and temporarily incapable of and temporarily incapable of self-support?
❑ No ❑ Yes

If *Yes*, what date do you anticipate this individual will recover and be able to return as a full-time student or seek employment?_____

Is the dependent fully compliant with treatment? ❑ No ❑ Yes

If *No*, would the prognosis be different if the dependent were compliant? Explain:

_____
_____
_____
_____

I hereby certify that all information provided in SECTION B is correct to the best of my knowledge.

_____	_____	_____
Attending Physician's Signature	Date	Medical Board License #
_____	_____	Attending Physician's Address:
Print Attending Physician's Name	Physician's Telephone Number	_____
		_____
		_____