Disabled Overage Dependent Certification

This form is used to determine if your adult dependent child meets your plan's eligibility for coverage after age 26.

REQUIREMENTS

Any unmarried dependent child, regardless of age, will be covered while your coverage remains in force if the child:

(1) is incapable of self-sustaining employment by reason of mental illness, developmental disability, or physical disability; and

(2) became so incapable prior to turning 26; and

(3) is chiefly dependent upon you for support and maintenance; and

(4) remains in such condition.

You have 31 days from the date of the child's attainment of age 26 to submit an application to request that the child be included under your coverage and provide proof of the child's incapacity. Your plan has the right to check whether a child qualifies and continues to qualify under this section at any time.

INSTRUCTIONS

You or your physician may submit the information requested in this form. Please complete all required sections and sign the attestation statement at the end. Judi Health must receive the completed form within 31 days of the dependent turning 26.

- Subscriber to complete Sections 1 - 5 of the form and sign the applicable fields
- Physician must complete and sign the applicable fields in Section 6
- Include any of the following items to support the request:
    - Copy of the Social Security Disability Insurance (SSDI) Award Letter (if applicable)
    - Copy of the active Court Order for Legal Guardianship (if applicable)
    - Physician Attestation
    - Medical records or written documentation within the last three (3) months

The entirety of the form must be completed and sent together for processing. Please note that while we implement reasonable safeguards to protect your protected health information (PHI) sent through email, there is some risk your PHI could be read or otherwise accessed while in transit. If you prefer, you may instead mail or fax your information. Completed forms can be sent to:

Email: eligibility@judihealth.com

Fax: 833-FAX-JHLT (329-5458)

Mail: Judi Health Attn: Eligibility Dept 9450 SW Gemini Dr., #87234 Beaverton, OR 97008

Judi Health™

Section 1: Subscriber Information

Subscriber Name:	ID #:	Group #:
Address:		
City:	State:	Zip:

Section 2: Disabled Overage Dependent Information

Full Name of Disabled Dependent:	
Date of Birth:	Relationship to Subscriber:
Marital Status: ☐ Married ☐ Single	Address (if different than above):
Date of Disability:	Nature of Disability:
Does dependent have other/additional health insurance? ☐ Yes ☐ No If yes, provide the information below:	

Other Insurance Name:	Other Health Insurance ID #:	Customer Service Number:

Section 3: Has dependent ever been employed? If yes, complete this section

Is the dependent currently employed? ☐ Full Time ☐ Part Time ☐ Not Currently Employed
Provide name and address of dependent's current employer below:
If not currently employed, provide last date of employment:
Is dependent's current position with employer eligible for health insurance? ☐ Yes ☐ No If yes, is dependent carrying "own" health insurance? ☐ Yes ☐ No
If no, provide explanation as to why dependent is not carrying "own" coverage:

Section 4: Disability Information

Has the dependent been declared disabled by the Social Security Administration? ☐ Yes, please attach SSDI and/or SSI document(s) ☐ No
Has the dependent been placed in Legal Guardianship by a court order? ☐ Yes, please attach active court order ☐ No

Section 5: Attestation

I confirm I have completed the form in its entirety. I understand that it may be a crime to fill out this form with information I know is false or leave out information I know is important. Penalties may include imprisonment, fines, and denial of benefits.

I certify/attest that dependent meets the following criteria:

1. The dependent became disabled before reaching age 26; and
2. Is incapable of self-sustaining employment due to disability; and
3. The dependent relies primarily upon Subscriber (and/or spouse) for support and maintenance.

Subscriber's Signature: _____

Date: _____