State of Maryland
State Employee/Retiree Health Benefits Program
Certification of Disabled Dependent

This portion to be completed by Employee/ Retiree.

Employee/Retiree Name:	Employee/Retiree Social Security Number:
Dependent's Name:	Dependents Date of Birth: Month ________ Day ________ Year ________
Dependent's Sex: ☐ Male ☐ Female	Relationship to Employee/Retiree:
Dependent's Social Security Number:	Dependents Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Does this dependent reside with you? ☐ Yes ☐ No

Do you provide 100% or more of the dependent's support? ☐ Yes ☐ No

Is this dependent a current SSI recipient due to disability? ☐ Yes ☐ No

(Please enclose letter of determination from SSI)

Does this dependent have Medicare A or Part B? ☐ Yes ☐ No

Effective date: ____________

(Please enclose Medicare letter)

Signature of Employee/Retiree ____ Date _______________

This portion to be completed by Physician.

This portion outlines documentation to be submitted by the dependent's personal physician. Information must be current (i.e. the patient has been examined within the last 6 months for medical or 3 months for mental health.

Diagnosis ____________________ Date of onset of condition________________

Prognosis ____________________

Does this condition impose on the individual's ability to perform daily duties, maintain gainful employment or maintain student status?

☐ Yes ☐ No

Is the dependent in an institution? ☐ Yes ☐ No

Institution name: _____________________________________

Name of Physician (please print) _______________________ Phone Number __________________

Physician's Address ____

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Signature of Physician ____ Date _______________

For medical disability request, please attach the most recent history and physical, which document the diagnosis and the functional limitations.

For mental health disability request, please attach the most recent psychiatric evaluation which documents the diagnosis and the functional limitations

All Protected Health Information provided by your dependent's physician will be kept confidential in accordance with the HIPAA law and will only be reviewed for the purpose of determining your dependent's disability.

Once this form and medical notes are returned along with the signed authorization form, we will forward all documentation to the medical plan for a determination. Please allow 30 days.