



STATE OF RHODE ISLAND & PROVIDENCE PLANTATIONS

Department of Administration – Office of Employee Benefits

Phone: (401) 222-3160 Fax: (401) 222-2964



Statement of Dependent Eligibility Due to Mental or Physical Handicap

EMPLOYEE'S STATEMENT								<i>Answer all questions below. Omitted information will cause delays.</i>							
Name (Print) First Middle Last				Social Security #				Date of Birth				Sex <input type="checkbox"/> M <input type="checkbox"/> F			
Present Address: Street				City State Zip Code				Phone Number				Marital Status <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> D			
DEPENDENT INFORMATION															
Name (Print) First Middle Last				Social Security #				Date of Birth				Sex <input type="checkbox"/> M <input type="checkbox"/> F			
Present Address: Street				City State Zip Code				Relationship to Employee				Marital Status <input type="checkbox"/> S <input type="checkbox"/> M			
Name and address of dependent's current employer															
If not now employed, give date the dependent was last employed				Estimate income of dependent from all sources \$ monthly				Is dependent receiving social security income? <input type="checkbox"/> Yes <input type="checkbox"/> No				Percentage of support of dependent supplied by employee: %			
Is dependent permanently residing in employee's household? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, explain</i>															
Is dependent listed as a dependent in your last Federal Income Tax Return? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, explain</i>															
I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.															
Employee Signature												Date			
PHYSICIAN'S STATEMENT												<i>(Any fee for the completion of this statement is to be paid by the employee.)</i>			
												<i>Answer all questions below. Omitted information will cause delays.</i>			
Patient's Name: First Middle Last								Patient's Date of Birth							
Is the dependent presently incapable of self-sustaining employment by reason of:												Date dependent became incapable of self-sustaining employment:			
Mental Retardation? <input type="checkbox"/> Yes <input type="checkbox"/> No				Physical Handicap? <input type="checkbox"/> Yes <input type="checkbox"/> No				Mental Handicap? <input type="checkbox"/> Yes <input type="checkbox"/> No				Other (Explain) _____			
Diagnosis of condition causing incapacity. If mental retardation is present, give degree of retardation. Give as much detail as possible. Please give date and report of surgery, X-rays, electrocardiograms, or other special tests. Use a separate sheet of paper if necessary.															
Does the patient have a job? <input type="checkbox"/> Yes <input type="checkbox"/> No				Do you know what the patient's job is? <input type="checkbox"/> Yes <input type="checkbox"/> No				Do you know what duties the patient's job requires? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Has this patient been able to do full or part-time work of any kind? <input type="checkbox"/> No <input type="checkbox"/> Yes, From _____(Date)								Will the patient be capable of self-support? <input type="checkbox"/> No <input type="checkbox"/> Yes, From _____(Date)							
The patient is presently (check one) <input type="checkbox"/> Ambulatory <input type="checkbox"/> Bed confined <input type="checkbox"/> House confined <input type="checkbox"/> Hospital confined															
Physician's Name (Print)								Address				Phone Number (Include Area Code) ()			
I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.															
Physician's Signature												Date			
OFFICE USE ONLY															
Accepted by:												Date:			

The Rhode Island State Employee Health Plan complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Language assistance services, free of charge, are available to you. Call (401) 222-3160.

Submit completed form to the address at the top of page.