UT Benefits
THE UNIVERSITY of TEXAS SYSTEM

Incapacitated Over Age Dependent

APPLICATION FOR UT BENEFITS COVERAGE

Please complete electronically and/or print clearly and make sure to sign and submit this form to your institution HR/Benefits Office. Keep a copy for your records. You may refer to the UT Benefits Handbook and plan guides for details at **www.utsystem.edu/offices/employee-benefits/**

A EMPLOYEE / RETIREE INFORMATION

Name (Last, First, Middle)			**HR STAFF USE ONLY** Purpose of this application: To determine insurance eligibility as an incapacitated Over Age Dependent.	
Benefits ID (BID) / Employee ID	Home Phone		Benefits Representative	
Street Address			E-mail Address or Phone Number	
City	State	Zip Code	HR Fax	Date Entered
- Select Institution - Employing UT Institution			Institution or State Agency Code (SAC)	

B COVERAGE AND DEPENDENT INFORMATION

○ I am requesting continuance of coverage for my child because the child has reached the limiting age.*

○ I am newly eligible for coverage under the UT group insurance plan and my child was covered by my previous group insurance plan as a dependent.*

* I understand that coverage would normally terminate when my child reaches a certain age (age 26 for UT SELECT Medical only, or age 25 for all other UT Benefits). I understand that my child is eligible for coverage only if I can establish that my child is mentally or physically incapacitated to the extent that the child cannot engage in self-sustaining employment and the condition commenced prior to such child's attainment of the limiting age.

C AUTHORIZATION AND ACKNOWLEDGEMENT

Dependent Certification

By enrolling your Dependents you certify you understand the definition of a Dependent and acknowledge that misrepresentation by an Employee or Retired Employee of benefit eligibility requirements constitutes a violation of the Office of Employee Benefits official policy and a violation of The University of Texas System Rules and Regulations of the Board of Regents, Series 31013(1). Possible sanctions for such a violation range from a reprimand to dismissal. A Subscriber who enrolls an ineligible Dependent in program coverage may be responsible for reimbursement of prior premiums or claims incurred by the Dependents. A verified misrepresentation by an Employee or Retired Employee shall be reported by OEB to the appropriate institution for investigation and possible sanctions. Deliberate misrepresentation of Dependent eligibility by a Subscriber may constitute criminal fraud and result in a referral to a law enforcement office.

Definition of Dependent

For UT SELECT Medical: Your spouse as defined by the Texas Family Code; your child(ren) under age 26 including stepchildren and adopted children; your unmarried grandchild under age 25 if the child qualifies and is claimed as your dependent for federal tax purposes; certain children over age 26 who are determined by OEB to be medically incapacitated and are unable to provide their own support; and children for whom you are named a legal guardian or who are the subject of a medical support order.

For all other UT Benefits: Your spouse as defined by the Texas Family Code; your unmarried child(ren) under age 25 including stepchildren and adopted children; your unmarried grandchild under age 25 if the child qualifies and is claimed as your dependent for federal tax purposes; certain children over age 25 who are determined by OEB to be medically incapacitated and are unable to provide their own support; and children for whom you are named a legal guardian or who are the subject of a medical support order.

Definition of Dependent *(Continued)*

A Dependent does not mean anyone who is on active duty in the armed forces of any country (for coverage other than UT SELECT Medical). A dependent that has coverage under any plan for which the dependent already receives a premium sharing contribution from the State of Texas is not eligible for premium sharing under the UT SELECT plan. This includes any Employee, Retiree or Dependent coverage under another University of Texas or Texas A&M plan, and any plan offered by a Texas state agency, and certain public school districts.

Notice About Social Security Numbers (SSNs)

Federal law requires the University of Texas System to report income information and the SSN for all employees to whom compensation is paid. Employee's SSNs are also maintained and used for payroll and benefits and verification purposes as required and permitted by state and federal law. Nonemployee SSNs are requested for use and disclosure for benefits and verification purposes as permitted by state and federal law.

State Government Privacy Policy

With few exceptions, you are entitled to request and to receive and review under Sections 552.021 and 552.023 of the Texas Government Code (the Texas Public Information Act), information that UT System Administration or another UT System institution collects and retains about you. Under Section 559.004, you are entitled to have incorrect information that is retained about you corrected. You can obtain information about how to request access to such information at:
www.utsystem.edu/ogc/openrecords/access.htm.

By signing this form, I certify that: all information I have provided is correct to the best of my knowledge; that I will comply with the UT System Uniform Group Insurance Program rules and Texas Insurance Code Chapter 1601; and that I have read and understood all of the notices provided on this form. I further understand that it is my sole responsibility to notify the University of Texas System in writing of any changes that may affect dependency status.

Employee / Retiree Signature	Date

D PHYSICAL CAPACITY QUESTIONNAIRE

DEPENDENT INFORMATION

Dependent Name (Last, First, Middle Initial)		Date of Birth (mm/dd/yyyy)
Social Security Number or BID	Marital Status	Employment Status

Means of Support

PARENT / GUARDIAN INFORMATION

Does the Dependent reside with you? ☐ Yes ☐ No	If yes, is the Dependent capable of residing alone?
Has the Dependent been classified as disabled by a government agency? ☐ Yes ☐ No	If yes, please provide the Agency name:

Describe the diagnosis of the mental or physical incapacitation that renders your child incapable of self-sustaining employment:

Provide the name and contact information of a health provider who has confirmed this diagnosis:

You must provide a copy of your most recent income tax statement or other records such as receipts or cancelled checks that indicate that this child is dependent upon you for the majority of the child's care and support. PLEASE HAVE YOUR ATTENDING PHYSICIAN SIGN BELOW.

ATTENDING PHYSICIAN INFORMATION

Diagnosis or ICD-9 Code(s)

Prognosis	Date of Onset (mm/dd/yyyy)

Symptoms

Has the patient's impairment lasted, or can it be expected to last for at least the next twelve months?

☐ **Yes** ☐ **No**

Do emotional or cognitive factors contribute to the severity of your patient's symptoms and functional limitations including their ability to complete activities of daily living, such as bathing and/or self-care?

☐ **Yes** ☐ **No** **If yes, please explain below**

Do symptoms of pain interfere with your patient's ability to perform simply daily tasks?

☐ Yes ☐ No If yes, please explain below

Do the identified symptoms above exist to the extent that they would prohibit your patient from gaining self-sustaining employment?

☐ Yes ☐ No If yes, please explain below

Physicians Signature	Date

E UT MEDICAL DIRECTOR INFORMATION (UT SYSTEM USE ONLY)

Do you recommend approval for continued coverage as an incapacitated overage dependent?

☐ Yes ☐ No

If approved, do you recommend annual recertification or permanent coverage?

☐ Annual Recertification ☐ Permanent Coverage

If the application for continued coverage is denied, what is the basis of your denial?