



**DISABLED DEPENDENT CERTIFICATION**

**Employee Name:** \_\_\_\_\_

**Employee SSN:** \_\_\_\_\_

**Dependent Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**I declare under penalty of perjury that the above noted dependent:**

(Please check only one of the following boxes)

**Is my qualified dependent who is incapable of self-sustaining employment as the result of mental or physical handicap, and who remains chiefly dependent upon me for financial support.** (Attach attending physician certification.)

**Was formerly my qualified dependent, but is no longer chiefly dependent on me for financial support as of:**

\_\_\_\_\_ (Status change date)

**I understand that the above certification will be used as a basis for determining dependent eligibility under the Plan, and that it is my obligation to advise the Plan of any change in dependency status.**

**I promise to notify the Fund Office immediately if this dependent becomes capable of self-sustaining employment or if this dependent ceases to be chiefly dependent upon me for financial support.**

**SIGNED:** \_\_\_\_\_  
(Covered Employee)

**DATE:** \_\_\_\_\_



**PHYSICIAN CERTIFICATION OF DISABILITY**

**Patient Name:** \_\_\_\_\_

**Employee Name:** \_\_\_\_\_

**I certify that the above patient is incapable of self-sustaining employment due to the following physical and/or mental handicap:**

\_\_\_\_\_  
(Diagnosis and concurrent conditions)

\_\_\_\_\_  
(Additional comments or clarification)

**The above patient has been totally disabled since:** \_\_\_\_\_  
(Date)

**He/she is expected to remain totally disabled until:** \_\_\_\_\_  
(Date)

**Last evaluation:** \_\_\_\_\_ **Next evaluation:** \_\_\_\_\_  
(Date) (Date)

***PLEASE ATTACH A COPY OF THE PATIENT'S MOST RECENT MEDICAL EVALUATION IN CONNECTION WITH THE DISABLING CONDITION.***

**Physician Signature:** \_\_\_\_\_  
(Name and degree)

**Date Signed:** \_\_\_\_\_

**Physician Name:** \_\_\_\_\_  
(Please Print Full Name)

**Physician Address:** \_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City, State, and Zip)

**Telephone Number:** \_\_\_\_\_