

# CSEA Employee Benefit Fund Certification of Disability Form



Dependent children are covered until they reach age 26. However, if your dependent is either physically or mentally disabled, you may continue his/her coverage beyond age 26. To qualify, the disability must have occurred before reaching age 26.

## MAIL COMPLETED CLAIM TO

CSEA Employee Benefit Fund  
PO Box 516  
Latham, NY 12110-0516

## TO BE COMPLETED BY MEMBER (PLEASE PRINT)

Member's Name \_\_\_\_\_ EBF ID# \_\_\_\_\_

Mailing Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Daytime Phone # \_\_\_\_\_ Email \_\_\_\_\_

### I request continuation of coverage for the child named below who is totally disabled:

Dependent's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

## TO BE COMPLETED BY PHYSICIAN (PLEASE PRINT)

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Is dependent capable of self support by reason of a mental or physical disability?    **Yes**     **No**

Date dependent above became incapable of self support \_\_\_\_\_ Prognosis (estimated in months or years) \_\_\_\_\_

Is dependent confined:    At home     Institution     Name of institution \_\_\_\_\_

Please state the **diagnosis name** causing disability. Indicate the degree of severity. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Office Stamp