CSEA Employee Benefit Fund Certification of Disability Form

MAIL COMPLETED CLAIM TO



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.

CSEA Employee Benefit Fund PO Box 516 Latham, NY 12110-0516			
TO BE COMPLETED BY MEMBER (PL	EASE PRINT	Γ)	
Member's Name		-	
Mailing Address			Apt #
City		State	Zip Code
Daytime Phone #	Email		
I request continuation of coverage for the	e child named	l below who is totally	disabled:
Dependent's Name		Date of Birth	
Member's Signature		Date	
TO BE COMPLETED BY DUVELCIAN (DI EASE DDI	INT	
TO BE COMPLETED BY PHYSICIAN (Physician's Name	_	-	
Address City			
ls dependent capable of self support by reason of a ment			•
Date dependent above became incapable of self support			
Is dependent confined: At home Institution	Name o	of institution	
Please state the diagnosis name causing disability. Indicat			
Physician's Signature		Date	
		Physician's Office Stamp	
		,	•