CSEA Employee Benefit Fund
Certification of Disability Form

CSEA NEW YORK Employee Benefit Fund

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.

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 # _____

Date disability began_____

Disability Status? ☐ Temporary ☐ Permanent

If **TEMPORARY**, estimated duration: _____

Is the patient capable of self support? ☐ Yes ☐ No

Diagnosis name and severity_____

_____

_____

Physician's Signature _____ Date _____

Physician's Office Stamp

MAIL COMPLETED CLAIM TO

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