Disabled Dependent Form

MERITAIN HEALTH℠
An Aetna Company

Complete and Return to:
Meritain Health
Eligibility Dept.
P.O. Box 27337
Lansing, MI 48909
Fax: 716.541.6672
Email: Forms.Direct@meritain.com

Meritain Health Welcomes You! If you have a disabled dependent, you must fill out this form to expedite claims processing and enhance your level of service.

If we do not receive this information, it will delay the processing any payment of your claims.

Section 1. EMPLOYEE INFORMATION *(Please print)*	
Employee Name	Social Security Number
Name of Company (your employer):	

Please complete the following information in order for Meritain Health to determine eligibility for your dependent.

Section 2. DEPENDENT INFORMATION *(Please print)*		
Name of Dependent	Date of Birth	
1. Is the dependent unable to be self-supporting due to sickness or injury?	❑ **Yes**	❑ **No**
2. Is the dependent principally/solely supported by you?	❑ **Yes**	❑ **No**
3. Is the dependent receiving income from sources other than you?	❑ **Yes**	❑ **No**
4. Does the dependent reside in your household?	❑ **Yes**	❑ **No**
5. Is the dependent covered under any other coverage?*****	❑ **Yes**	❑ **No**
****If yes, please complete the other insurance coverage form***		

SIGNATURE AND AUTHORIZATION		
I certify that the information I have set forth in this application is true and correct to the best of my knowledge. No information has been knowingly withheld or omitted concerning my dependents or me. I understand that providing false information in this application is a crime and may result in the denial of claims or cancellation of coverage. In addition I may be subject to civil and/or criminal penalties.		
EMPLOYEE SIGNATURE	PRINT EMPLOYEE NAME	DATE

TO BE COMPLETED BY THE DEPENDENT'S PHYSICIAN *(Please print)*		
When did the present illness or injury occur?		
Is the patient incapacitated and unable to be self-supporting due to the illness or injury?		
Diagnosis and description of the medical history causing the disability.	ICD 10 Code	
Remarks (Please provide additional documentation if necessary).		
Print Physician's Name	Phone (including area code)	
Address	City	State, Zip
PHYSICIAN'S SIGNATURE		DATE