



Please return the completed form.

By Mail: PO Box 1271 MS5C
Portland, OR 97207-1271

By Fax: 1 (866) 303-5117

Affidavit of Qualifying Incapacitated Dependent Eligibility

SECTION 1 - STATEMENT OF DEPENDENT'S ELIGIBILITY (to be completed by the Employee)

Employee's Name			ID Number		
Employee's Address		City	State	ZIP Code	Group Number
Dependent's Name			Dependent's Birthdate		
Dependent's Relationship to Employee			Dependent's Marital Status		
Dependent's Address (if not residing with Employee)		City	State	ZIP Code	
Please explain why dependent does not reside with employee.					
Is dependent currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			Date Employment Began _____		
Position Held _____			Average Hours Worked Per Week _____		
Dependent's Current Employer's Name					
Current Employer's Address		City	State	ZIP Code	
Was dependent previously employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			Dates of Employment _____ to _____		
Position Held _____			Average Hours Worked Per Week _____		
Dependent's Previous Employer's Name					
Dependent's Previous Employer's Address		City	State	ZIP Code	
Does dependent have other health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the name of the carrier, Employee name, policy number and carrier's phone number:					
Is the dependent eligible for or have Medicare coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the type of coverage, effective date and the Medicare Number (please include the alpha prefix):					
Has the dependent been declared disabled by the Social Security Administration? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the date of acceptance? _____ (please attach a copy of the SSI acceptance letter)					
What is the dependent's estimated gross monthly income from all sources \$ _____			What is the percentage of dependent's financial support supplied by Employee _____ %		
<p>I certify that _____, meets the following criteria:</p> <p style="text-align: center;">Name of incapacitated dependent (please print)</p> <ol style="list-style-type: none"> 1) Has been continuously covered by health insurance as my dependent with no break in coverage of more than 63 days; 2) Is incapable of self-sustaining employment due to incapacitation related to developmental disability, medical disability, and/or mental disorder; and 3) Is significantly dependent upon Employee (and/or Employee's spouse) for support and maintenance. 					
Signature of Employee			Date		

