

Key Account/National Account  
Statement of Dependent Eligibility Beyond Limiting  
Age Due to Mental or Physical Disability



**Employee's Statement** **Answer all questions below.  
Omitted information will cause delays.**

Name (Print)	First	Middle	Last	Social Security Number	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Present Address:	Street	City	State	Zip Code	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced	Phone (Including Area Code) ( )

**Dependent Information**

Name (Print)	First	Middle	Last	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Present Address:	Street	City	State	Zip Code	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Relationship to Employee

Name and address of dependent's current employer

Estimated income of dependent from all sources \$ _____ monthly	Percentage of support by the employee for the dependent _____ %	<input type="checkbox"/> Conservatorship/Guardianship <input type="checkbox"/> Court ordered/Divorce Decree
Is dependent listed as a dependent in your last Federal Personal Income Tax Return? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Explain		
Is dependent employed? <input type="checkbox"/> Yes <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> No Date last employed _____		

Explanations

I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT.	Date
▶ Signed (Employee)	

**Physician's/Surgeon's Statement** **(Any fee for the completion of this statement is to be paid by the employee.)  
Answer all questions below. Omitted information will cause delays.**

Patient's Name	First	Middle	Last	Patient's Date of Birth
Is this dependent presently incapable of self-sustaining employment by reason of: Intellectual/Developmental Disability? Physical Handicap? Mental Handicap? Other (explain)				Date dependent became incapable of self-sustaining employment.
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No				

Please provide the diagnosis of the condition(s)causing the incapacitation and provide supportive documentation of the physical and/or functional limitations that prevent the dependent from being capable of self support. May attach any written documentation or medical records.

Is the dependent able to do full or part time work? <input type="checkbox"/> No <input type="checkbox"/> Yes, From _____ Date	Will the patient be capable of self support? <input type="checkbox"/> No <input type="checkbox"/> Yes, From _____	
The patient is presently (check one) <input type="checkbox"/> Ambulatory <input type="checkbox"/> Bed confined <input type="checkbox"/> House confined <input type="checkbox"/> Hospital confined		
Physician's/Surgeon's Name (Print)	Address	Phone (Including Area Code) ( )

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▶ Signed	