Lucent Health

DISABLED DEPENDENT INFORMATION FORM

This form is to be completed by the Employee. Please sign and date where indicated. Please complete a separate form for each Dependent.

Use a separate sheet or the back of this form, if necessary.

Return to:
Lucent Health
P O Box 2318
Rancho Cordova, CA 95741
Phone: 800-331-5301
Fax: 916-669-0573

Employer: _____

Employee: _____ SSN:_____

Dependent Name: _____ Date of Birth: _____

Dependent SSN: _____ Sex: _____

According to the language in your Plan Document, if an unmarried child is (on the date such child's coverage would otherwise terminate due to age) incapable of self-sustaining employment by reason of intellectual disability or physical handicap, and such incapacity commenced prior to the date such child's coverage would otherwise terminate, and such child is chiefly dependent upon the Employee for support and maintenance, the Plan will, upon payment of the applicable premium, continue coverage for such unmarried child so long as such Employee's coverage remains in force and such incapacity continues; provided proof of such incapacity is submitted to the Plan within 30 days of the date dependent coverage would otherwise have terminated.

Is the Dependent unmarried?	☐ YES	☐ NO
Is Dependent totally and permanently disabled?	☐ YES	☐ NO
Does the Dependent rely chiefly upon you for support and maintenance?	☐ YES	☐ NO

Please provide a detailed explanation of his or her degree of disability:

_____

_____

_____

_____

Please return with this form with a copy of a physician's statement or other proof of disability (such as a Social Security Disability Award letter or similar documentation from your state or local government).

I hereby certify that the above statements are true and complete to the best of my knowledge and I realize that failure to provide accurate information may cause a loss of benefits.

_____ _____

Employee Signature **Date**