

# CSEA Employee Benefit Fund Certification of Disability Form



Dependent children are covered until they reach age 19. However, if your dependent is unmarried, and either physically or mentally disabled, you may continue his/her coverage beyond age 19. To qualify, the disability must have occurred before reaching age 19.

## MAIL COMPLETED CLAIM TO

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

## 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 son/daughter 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 # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Is dependent incapable of self support by reason of a mental or physical disability? **Yes**  **No**

Date dependent above became incapable of self support \_\_\_\_\_ Prognosis (estimated in months or years) \_\_\_\_\_

Is dependent confined: At home  Institution  Name of institution \_\_\_\_\_

Please state the **diagnosis name** causing disability. Indicate the degree of severity. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Office Stamp