STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BENEFITS ADMINISTRATION
312 Rosa L. Parks Avenue
Suite 1900 William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243
Phone (615) 741-4517 or (866) 576-0029
FAX (615) 253-8556

EMPLOYEE:

EDISON EMPLOYEE ID:

DATE:

RE: Incapacitated Dependent Procedures

Under the State of Tennessee's eligibility rules an incapacitated child, who is either mentally or physically disabled and incapable of earning a living, may continue health, dental or vision coverage beyond age 26 as long as the incapacity existed prior to their 26th birthday and they were already insured under the state's group insurance program.

Attached is the "Certification of Incapacitation for Dependent Child" form to be completed for your dependent. You should complete the top portion of this form and the dependent's physician should complete the physician's statement portion. The physician needs to provide as much information as possible to support the incapacitation decision. After the form is completed, you should mail the form to Benefits Administration at the address listed above for further processing. **The form MUST be received by Benefits Administration prior to the child's 26th birthday.** It will take approximately three to four weeks for the Plan's underwriter to complete the Incapacitation process.

If coverage is approved, additional proof may be required periodically to review the incapacitation status.

Should you have any questions or concerns regarding this matter, you may contact Benefits Administration at 1-800-253-9981.

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

CERTIFICATION OF INCAPACITATION FOR DEPENDENT CHILD

State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 615.741.3590 or 800.253.9981 • fax 615.741.8196

EMPLOYEE INFORMATION

EMPLOYING AGENCY NAME			BUDGET CODE/DEPT ID
EMPLOYEE NAME	EMPLOYEE ID (IF KNOWN)	SOCIAL SECURITY NUMBER	BIRTHDATE
DEPENDENT CHILD NAME		SOCIAL SECURITY NUMBER	BIRTHDATE

I certify that my dependent child is incapable of earning a living regardless of age and is chiefly dependent upon me for support and maintenance. I agree to provide annual proof if requested.

SIGNATURE OF EMPLOYEE _____ DATE _____

PHYSICIAN'S STATEMENT (if there is not adequate space, please attach a history to this form)

DIAGNOSIS

DATE YOU FIRST ATTENDED DEPENDENT CHILD (MM/DD/YY)	DATE YOU LAST SAW PATIENT (MM/DD/YY)

DEGREE OF INCAPACITY

HOW LONG HAS THE MENTAL OR PHYSICAL INCAPACITY EXISTED?

HOW LONG IS THIS INCAPACITY EXPECTED TO CONTINUE?

TREATMENT

PROGNOSIS

IN YOUR OPINION, IS THE DEPENDENT CHILD CAPABLE OF SELF-SUPPORT?

❑ YES ❑ NO IF NO, WHAT PREVENTS SUCH SUPPORT?

CAN THIS DEPENDENT CHILD PERFORM ANY TYPE OF WORK?

❑ YES ❑ NO IF YES, EXPLAIN

PLEASE LIST THE NAME, ADDRESS AND TELEPHONE NUMBER OF ALL THE PHYSICIANS OR OTHER HEALTH CARE PROVIDERS YOU ARE AWARE OF THAT ARE CURRENTLY TREATING THIS DEPENDENT FOR HIS OR HER MENTAL OR PHYSICAL INCAPACITY

ATTENDING PHYSICIAN'S NAME AND ADDRESS (INCLUDE STREET, CITY, STATE, ZIP CODE)

ATTENDING PHYSICIAN'S SIGNATURE	DATE