OKLAHOMA
Office of Management
& Enterprise Services

Employees Group Insurance Division

Disabled Dependent Assessment

EMPLOYEE INFORMATION

SSN or Member ID _____

Employee name _____
(print) First MI Last

Mailing address _____

_____ _____ _____
City State ZIP code

Email _____

Home phone _____ Mobile _____ Work _____

DEPENDENT INFORMATION

Dependent name _____
(print) First MI Last

Date of birth _____ SSN _____

Relationship ☐ Son ☐ Daughter ☐ Other _____

Dependent resides ☐ In home with member ☐ In a nursing home ☐ In separate housing

☐ Other (explain) _____

Is this child unmarried and primarily supported by you? ☐ Yes ☐ No

Please check each that applies for the coverage you want:

☐ Health ☐ Dental ☐ Vision Dependent Life: ☐ Premier Option ☐ Standard Option ☐ Low Option

AUTHORIZATION (Please read before signing.)

I authorize release of any and all information necessary to complete the review to determine if the above dependent is eligible to enroll or continue on my insurance through OMES Employees Group Insurance Division. I understand that any fee charged for this information is my responsibility as the member requesting coverage and is not eligible for payment, reimbursement or consideration by EGID. It is further understood and agreed that failure to provide complete and accurate information might affect my dependent's insurability and may constitute grounds for retroactive termination of coverage.

Member signature _____ Date _____

Dependent signature (if capable) _____ Date _____

Note: First-time applicants must attach a copy of your most recent income tax return reflecting support of the dependent. If you are requesting extended coverage for currently covered dependents, you must submit this form at least 30 days prior to the dependent's 26th birthday.

ATTENDING PHYSICIAN MUST COMPLETE THIS SECTION

The information you provide about the limitations and abilities of this patient will determine if coverage is approved, denied or continued under the member's policy. Please complete this section by checking all appropriate boxes. Provide additional information on an attached sheet.
Note: Documentation must confirm the disability occurred before the patient reached age 26.

Condition is ☐ Mental ☐ Physical Condition began _____

Diagnosis _____ ICD code(s) _____

Note: Diagnosis and current ICD codes must be completed in order for the assessment to be reviewed.

1. Mobility ☐ Full ☐ Partial ☐ Total

   ☐ Specify _____
   (Bedridden, wheelchair, etc.)

2. Paralysis ☐ None ☐ Partial ☐ Total

   ☐ Specify _____
   (Bedridden, wheelchair, etc.)

3. Mental ☐ Irrational ☐ Confused ☐ Impulsive ☐ Hallucinating ☐ Delusional

   ☐ Aggressive ☐ Fearful ☐ Withdrawn ☐ Suicidal ☐ Homicidal

   ☐ Others – List _____

   _____

4. Medical ☐ Seizures ☐ Tremors ☐ Epilepsy ☐ Frailty ☐ Swelling

   ☐ Labored breathing ☐ Cardiovascular disease ☐ Respiratory disease

   ☐ Others – List _____

   _____

5. Prognosis ☐ Excellent ☐ Good ☐ Poor ☐ Terminal

6. List any special needs of patient _____

   _____

7. Check the box that best applies to patient:

   ☐ Patient is unable to live independently and is not capable of self-support.

   Provide details _____

   _____

   ☐ Patient is able to live independently with monitoring and is capable of self-support.

Signature of attending physician _____ Date _____

Return completed form to:
Employees Group Insurance Division
Health Care Management Unit
P.O. Box 11137
Oklahoma City, Oklahoma 73136-9998