PRESBYTERIAN

DEPENDENT ELIGIBILITY DISABLED STATUS QUESTIONNAIRE

INSURED:_____

ID #:_____

GROUP #:_____

EFFECTIVE DATE:_____

RE:_____ DOB:_____

1. DOES THIS MEMBER RESIDE WITH YOU AT ALL TIMES?_____ IF NO, PLEASE EXPLAIN:

_____

_____

_____

_____

2. DO YOU CLAIM THIS MEMBER AS A DEPENDENT ON YOUR FEDERAL INCOME TAX? _____ PLEASE SEND A COPY OF YOUR LAST YEAR'S TAX RETURN AND THE DEPENDENT'S TAX RETURN IF FILED SEPARATELY.

3. HAS THIS MEMBER BEEN EMPLOYED ANYTIME WITHIN THE LAST TWELVE (12) MONTHS?_____

   IF YES, PLEASE EXPLAIN:

_____

_____

_____

_____

4. IS THIS MEMBER RECEIVING MEDICAID BENEFITS OR MEDICARE DISABILITY BENEFITS?_____ PLEASE SEND A COPY OF ANY DISABILITY AWARD.

5. HAS THIS MEMBER BEEN EVALUATED IN THE LAST TWELVE (12) MONTHS BY A PHYSICIAN? _____ PLEASE SEND A COPY OF THE LATEST EVALUATION MADE BY A PHYSICIAN. IF THE DEPENDENT HAS NOT BEEN EVALUATED RECENTLY, PHP MAY REQUEST YOU HAVE ONE DONE OR ASK FOR COPIES OF MEDICAL RECORDS TO RETAIN ON FILE.

IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH PAGES TO THIS FORM.

_____ _____

INSURED'S SIGNATURE DATE

RETURN COMPLETED FORM AND DOCUMENTATION TO:

PRESBYTERIAN HEALTH PLAN
ATTN: HEALTH SERVICES
PO BOX 27489
ALBUQUERQUE, NM 87125-9911