Asuris Northwest Health
528 East Spokane Falls Boulevard
Suite 301
Spokane, WA 99202

Please return the completed form.
By Mail: PO Box 1106
Lewiston, ID 83501
By Fax: 1 (866) 303-5117

Affidavit of Qualifying Incapacitated Dependent Eligibility for Groups of 101+

SECTION 1 - STATEMENT OF DEPENDENT'S ELIGIBILITY (to be completed by the Employee)

Employee's Name | ID Number

Employee's Address | City | State | ZIP Code | Group Number

Dependent's Name | Dependent's Birthdate

Dependent's Relationship to Employee | Dependent's Marital Status ☐ Single ☐ Married

Dependent's Address (if not residing with employee) | City | State | ZIP Code

Please explain why dependent does not reside with employee.

Is dependent currently employed? ☐ Yes ☐ No | Date Employment Began_____

Position Held_____ | Average Hours Worked Per Week_____

Dependent's Current Employer's Name

Current Employer's Address | City | State | ZIP Code

Was dependent previously employed? ☐ Yes ☐ No | Dates of Employment_____to_____

Position Held_____ | Average Hours Worked Per Week_____

Dependent's Previous Employer's Name

Dependent's Previous Employer's Address | City | State | ZIP Code

Does dependent have other health insurance coverage? ☐ Yes ☐ No
If yes, please provide the name of the carrier, employee name, policy number and carrier's phone number:

Is the dependent eligible for or have Medicare coverage? ☐ Yes ☐ No
If yes, please provide the type of coverage, effective date and the Medicare Number (please include the alpha prefix):

Has the dependent been declared disabled by the Social Security Administration? ☐ Yes ☐ No
If yes, what is the date of acceptance?_____(please attach a copy of the SSI acceptance letter)

I certify that_____, meets the following criteria:
Name of incapacitated dependent (please print)

1) Has been continuously covered by health insurance as my dependent with no break in coverage of more than 63 days **(please submit proof of continuous coverage with this affidavit)**;
2) Is incapable of self-sustaining employment due to incapacitation related to developmental disability, medical disability, and/or mental health; and
3) For a child over age 26, is significantly dependent upon employee (and/or employee's spouse) for support and maintenance.

▶ _____ _____
Signature of Employee **Date**

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SECTION 2 - STATEMENT OF INCAPACITATION (to be completed by the dependent's attending physician*)

Provider's Name				Provider's Telephone Number
Provider's Address	City	State	ZIP Code	Provider's Tax ID Number
Patient's Name				Patient's Birthdate

Date patient was last examined by attending physician. Dependent needs to be seen within one year of date of submission.	Nature of condition causing incapacity: ☐ Developmental Disability ☐ Mental Health ☐ Medical Disability ☐ Other (please explain)_____
Incapacitation is: ☐ Complete ☐ Partial_____% incapacitated	Incapacitation is: ☐ Temporary (estimated duration is)_____ ☐ Permanent At what age did patient become incapacitated?_____

Diagnosis of Condition Causing Incapacity: *(Give as much detail as possible. Please give dates of surgery, forward laboratory data and results of special tests, such as x-rays, EKG's, EEG's, etc. Attach additional pages as necessary.)*

Diagnosis_____

Comments to Support Incapacity_____

Is patient or will patient be capable of self-support? ☐ Yes ☐ No

If yes, from_____

Is patient able to perform full or part-time work of any kind? ☐ Yes ☐ No

Has patient previously been able to perform full or part-time work of any kind? ☐ Yes ☐ No

Attending Physician's Name (please print)	Attending Physician's Credentials
▶ **Signature of Attending Physician**	**Date**

***The attending physician's statements regarding incapacitation are necessary and important for Asuris Northwest Health's incapacitation determination; however Asuris Northwest Health is not bound by the physician's conclusion.**

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