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 (877) 369-3407

Affidavit of Qualifying Incapacitated Dependent Eligibility for Small Group (up to 100) Coverage

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	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
Position Held ______
Date Employment Began ______
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
Position Held ______
Date Employment Began ______ to ______
Average Hours Worked Per Week ______

Does dependent have other health insurance coverage? ☐ Yes ☐ No
If yes, please provide the name of the carrier, employee's 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 that was present before age 26; 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