Health Account Services
P.O. Box 942715
Sacramento, CA 94229-2715
(888) CalPERS (or **888**-225-7377)
TTY (877) 249-7442
Fax (800) 959-6545

MEMBER QUESTIONNAIRE for the CalPERS DISABLED DEPENDENT HEALTH BENEFIT

Member: Please complete all items. Incomplete forms will be returned causing a delay in benefits. CalPERS will determine eligibility upon receipt of this form and the physician's **MEDICAL REPORT for the DISABLED DEPENDENT BENEFIT.**

PART A: EMPLOYEE/ANNUITANT INFORMATION:	DEPENDENT INFORMATION:
Name: ______________________________ **Social Security Number (SSN):** ______-______-______ **Address:** ______________________________ **Telephone:** (____)______________	**Name:** ______________________________ **Social Security Number (SSN):** ______-______-______ **Address:** ______________________________ **Date of Birth:** ________________

PART B: Please provide the following information about the dependent who is seeking initial or continued enrollment or recertification in the health plan under the disabled dependent benefit. For purposes of this benefit, a person is considered disabled if the person is incapable of self-support (i.e., incapable of any substantial gainful activity) as a result of a physical or mental disabling injury, illness or condition. Mail this completed form to the above address.

MEMBER QUESTIONNAIRE			
			Health Insurance
1.			Is the dependent entitled to:
	Yes	**No**	Medicare Part A (hospital care)? (If yes, attach a copy of the dependent's Medicare card.)
	Yes	**No**	Medicare Part B (medical care)? (If yes, attach a copy of the dependent's Medicare card.)
	Yes	**No**	Other insurance? (If yes, specify the plan name and type of coverage.)
			Income and Support
2.	**Yes**	**No**	Is the dependent economically dependent upon you for his or her support?
	Yes	**No**	I claim the child as my dependent for income tax purposes.
3.			Is the dependent entitled to receive:
	Yes	**No**	Social Security Disability Insurance (SSDI)? If yes, as of what date? ____________
	Yes	**No**	Supplemental Security Income (SSI)? If yes, as of what date? ____________
			Additional Eligibility Questions
4.	**Yes**	**No**	Is the dependent working?
	Yes	**No**	Is the dependent incapable of self-support because of a physical or mental disability?
			If yes, what age did the dependent become physically or mentally disabled? _____

PART C: CERTIFICATION:

I hereby certify under penalty of perjury, that information provided by me is true and correct to the best of my knowledge. I also agree to provide supporting documentation such as, but not limited to, tax returns, statement of financial liability, or any other documents, when requested by my employer or CalPERS.

____ ________________
Employee/Annuitant Signature Date

PRIVACY INFORMATION

The Information Practices Act of 1977 and the Federal Privacy Act require the California Public Employees' Retirement System (CalPERS) to provide the following information to individuals who are asked to supply information. The information requested is collected pursuant to the Government Code Sections (20000. et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to supply the information may result in the System being unable to perform its functions regarding your status. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, P.O. Box 942702, Sacramento, CA 94229-2702.

Section 7(b), of the Privacy Act of 1974 (Public Law 93—579) requires that any federal, state, or local governmental agency which requests an individual to disclose his Social Security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it.

Health Account Services of the California Public Employees' Retirement System requests each enrollee's Social Security account number on a voluntary basis. However, it should be noted that due to the use of Social Security account numbers by other agencies for identification purposes, Health Account Services may be unable to verify eligibility for benefits without the Social Security account number.

Health Account Services of the California Public Employees' Retirement System uses Social Security account numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and state contribution for state employees
3. Billing of contracting agencies for employee and employer contributions
4. Reports to the California Public Employees' Retirement System and other state agencies
5. Coordination of benefits among carriers
6. Resolve member appeals/complaints/grievances with health plan carriers