Totally Disabled Dependent Form

Purpose
The purpose of this form is to let us know that you have a totally disabled dependent who is 26 years or older or who is turning 26, and needs to remain as a covered dependent on your benefit plan.

Definition
Per your Member Handbook, dependent children remain eligible up to age 26, regardless of student, marital, or financial status. An enrolled dependent child who reaches age 26 during a Benefit Year may remain enrolled as a dependent until the end of that benefit year. The dependent child's coverage shall end on the last day of the benefit year during which the dependent child becomes ineligible. A dependent child who is totally disabled at the time of attaining the maximum age of 26 may remain enrolled as a dependent until the disability ends. For purposes of this provision, a child is considered totally disabled while the child is and continues to meet both of the following criteria:

- Incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; **AND**
- Chiefly dependent upon the subscriber for support and maintenance.

Instructions
Fill out all sections of this form. The Medical Information section must be completed by your dependent's physician(s). Send your completed form and the following documents to Sharp Health Plan:

- Your dependent's physician's most recent medical notes and opinion
- Social Security Administration (SSA) documentation confirming your dependent's disability (if applicable)

Sharp Health Plan's medical director will review this information and approve or disapprove your dependent's status.

Submit
Please submit the finished form and required documents by mail, in person or by fax:

By mail or in person*:
Sharp Health Plan
Attn: Enrollment
8520 Tech Way, Suite 200
San Diego, CA 92123-9889

By fax:
Attn: Enrollment
1-858-499-8399

If you need assistance, we're here to help.
You can email Customer Care at **customer.service@sharp.com** or call 1-800-359-2002.
We are available to assist you Monday through Friday, 8 a.m. to 6 p.m.

Subscriber Information

First name:	Last name:	Middle initial:

ID#:	Home address:

City:	State:	ZIP code:

Dependent Information

First name:	Last name:	Middle initial:

ID#:	Birth date (MM/DD/YY):	Age:	Sex: ☐ M ☐ F
	(/ /)		

Home address (P.O. Box is not allowed):

City:	State:	ZIP code:

Phone number:	Employer name:	Occupation:
1-( )		

Has your dependent been determined to be disabled by the SSA?
☐ Yes (if yes, please attach SSA documentation confirming disability) ☐ No (if no, please answer the questions below)

Is your dependent a permanent resident of the subscriber's home? ☐ Yes ☐ No (if no, please explain):

Has your dependent ever been employed? ☐ Yes (if yes, give most recent dates of employment and type of employment): ☐ No

Does your dependent have other health coverage? ☐ Yes (if yes, please provide your dependent's other insurance information below) ☐ No

* Pending safety guidelines.

Name of other insurance:	Effective date (MM/DD/YY):	ID#:
	(/ /)	
Subscriber's name:	Subscriber's signature:	Date (MM/DD/YY):
		(/ /)

Physician's Statement of Disability

Purpose: The purpose of this form is to help Sharp Health Plan learn more about your dependent's disability status.

Instructions: All fields of this form must be completed. Include medical documentation to support your findings. A completed Totally Disabled Dependent Form must be submitted at the same time as this form.

NOTE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we ask that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or an individual's family member receiving assisted reproductive services.

Dependent Information		
First name:	Last name:	Middle initial:
Phone number: 1-( )	Birth date (MM/DD/YY): (/ /)	
Home address (P.O. Box is not allowed):		
City:	State:	ZIP code:

Medical Information (The remaining sections are to be completed by your dependent's physician(s).)	
1. Diagnosis (including any complications)	
Diagnosis (include ICD-10 or DSM IV-TR Code):	
Subjective symptoms:	
Objective findings (Please attach copies of current X-rays, EKGs, laboratory data and any clinical findings as applicable.):	
Are symptoms consistent with the clinical findings? ☐ Yes ☐ No, explain:	Is the illness work-related? ☐ Yes ☐ No
If pregnancy please indicate: LMP:	EDC: Actual delivery:
2. Dates of Treatment	
Date patient first visited you for this accident or illness (MM/DD/YY): (/ /)	Date patient was unable to work due to this accident or illness (MM/DD/YY): (/ /)
List frequency and date(s) patient was examined for this accident or illness (MM/DD/YY):	Date of last visit (MM/DD/YY): (/ /)
3. Nature of Treatment (including surgery and medications prescribed, if any)	
Date of hospitalization (MM/DD/YY): (/ /) through (/ /)	
Date of surgery (MM/DD/YY): (/ /)	Type of surgery:
Name of hospital:	Hospital address:

Medications	Type	Dosage

4. Physical Limitations (if applicable):

In an 8-hour workday, is your patient able to:

	0 hours	up to 2.5 hours	up to 5.5 hours	greater than 5.5 hours	**Cardiac** (If applicable) (American Heart Association)
Climb	☐	☐	☐	☐	☐ Class 1 - No Limitation
Balance	☐	☐	☐	☐	☐ Class 2 - Slight Limitation
Stoop	☐	☐	☐	☐	☐ Class 3 - Marked Limitation
Kneel	☐	☐	☐	☐	☐ Class 4 - Complete Limitation
Crouch	☐	☐	☐	☐	
Crawl	☐	☐	☐	☐	Blood pressure (last visit):
Reach	☐	☐	☐	☐	
Walk	☐	☐	☐	☐	
Sit	☐	☐	☐	☐	
Stand	☐	☐	☐	☐	

Please indicate the maximum level of ability (sedentary, light, medium, heavy) of your patient to:

Lift | Carry | Push | Pull

Sedentary = 10 lb. maximum, walking occasionally
Light = 20 lb. maximum, 10 lb. frequently
Medium = 50 lb. maximum, 25 lb. frequently, up to 10 lb. constantly
Heavy = 100 lb. maximum, 50 lb. frequently, 20 lb. constantly

5. Mental Impairment (if applicable):

Axis I:

Axis II:

Axis III:

Axis V: Current GAF:	Highest GA in past year:	Baseline:

Additional comments:

6. Return-to-Work Status (When was patient able to go to work?)

Patient's regular occupation (MM/DD/YY)	**Any other occupation** (MM/DD/YY)
(/ /) ☐ Full-time ☐ Part-time	(/ /) ☐ Full-time ☐ Part-time

7. Remarks

Physician's name (please print):	Degree and specialty:	Phone number: 1-( )

Federal tax ID#:	Address:

City:	State:	ZIP code:

Physician's signature:	Birth date (MM/DD/YY):
	(/ /)

Nondiscrimination Notice

Sharp Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Information in other formats (such as large print, audio, accessible electronic formats or other formats) free of charge
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Care at 1-800-359-2002.

If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with our Civil Rights Coordinator at:

- Address: Sharp Health Plan Appeal/Grievance Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY 711)
- Fax: 1-619-740-8572

You can file a grievance in person or by mail or fax, or you can also complete the online Grievance/Appeal form on the plan's website **sharphealthplan.com**. Please call our Customer Care team at 1-800-359-2002 if you need help filing a grievance. You can also file a discrimination complaint if there is a concern of discrimination based on race, color, national origin, age, disability or sex with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

The California Department of Managed Health Care is responsible for regulating health care service plans. If your grievance has not been satisfactorily resolved by Sharp Health Plan or your grievance has remained unresolved for more than 30 days, you may call toll-free the Department of Managed Health Care for assistance:

- 1-888-HMO-2219 Voice
- 1-877-688-9891 TDD

The Department of Managed Health Care's website has complaint forms and instructions online: **hmohelp.ca.gov**.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.

Language assistance services

English
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-359-2002 (TTY: 711).

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-359-2002 (TTY: 711).

繁體中文 **(Chinese)**
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-359-2002 (TTY: 711)。

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-359-2002 (TTY: 711).

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-359-2002 (TTY: 711).

한국어 **(Korean):**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-359-2002 (TTY: 711) 번으로 전화해 주십시오.

Հայերեն **(Armenian):**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-359-2002 (TTY (հեռատիպ)՝ 711).

(Farsi): فارسی
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما تماس بگیرید
.با .باشد می فراهم (TTY: 711) 1-800-359-2002

Русский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-359-2002 (телетайп: 711).

日本語 (Japanese):
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-359-2002 (TTY: 711)** まで、お電話にてご連絡ください。

(Arabic): قبير علا
(ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .تصل برقم
: رقم هاتف الصم والبكم .(711 1-800-359-2002

ਪੰਜਾਬੀ (Punjabi):
ਧਿਆਨ ਦਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY/TDD: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ **(Mon Khmer, Cambodian):**
បុរយ័ត្ននៈ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សវោជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-359-2002 (TTY: 711)។

Hmoob (Hmong):
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY: 711).

हिंदी (Hindi):
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-359-2002 (TTY: 711) पर कॉल करें।कॉल करें।

ภาษาไทย (Thai):
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-359-2002