State of New York
Department of Civil Service
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION

Statement of Disability

Dependent 19 Years of Age or Older

PS-451 (4/10)

PART A (*To Be Completed By Enrollee. Keep a copy of the completed form for your records.*)

Enrollee's Name *(Print)*	Health Insurance ID Number	Enrollee's Phone Number

Home Address *(No. and Street)*	City	State	Zip Code

I request continuation of NYSHIP coverage for the below named Dependent, who is disabled **and** incapable of self-support. * If the child is not my own, legally adopted (including a child in a waiting period prior to finalization of adoption) or dependent stepchild, I have completed and submitted a PS-*457 Statement of Dependence* with the requested documentation to my Agency Health Benefits Administrator.

Dependent Information Relationship (check one): ☐ Son ☐ Daughter ☐ Other Child*

Dependent's Name	Dependent's Social Security Number	Dependent's Date of Birth

Is Dependent presently employed? ☐ Yes ☐ No Is yes, explain:	Is Dependent married? ☐ Yes ☐ No	Percent of support provided by enrollee: _____ %

Is disabled dependent enrolled in Medicare A & B? ☐ Yes ☐ No If yes, provide copy of dependent's Medicare Card.

☐ Check if Dependent is permanently residing in your household and residence began prior to the age coverage would terminate. If otherwise, explain:

Personal Privacy Protection Law Notification

The information you provide on this application is requested for the principal purpose of enabling the NYS Department of Civil Service to process your request to continue enrollment for a disabled dependent 19 years of age or older in the New York State Health Insurance Program, Dental Program, Vision Program, and/ or other employee benefit fund program. The information will be used in accordance with Section 96 (1) of the Public Officers Law, also known as the Personal Privacy Protection Law. Failure to provide the information requested may prevent the Department from processing this application. This information will be maintained by the Director, Division of Employee Benefits, NYS Department of Civil Service, Albany, NY 12239. For information about the Personal Privacy Protection Law, call (518) 457-9375. For information about NYSHIP Eligibility for Disabled Dependents, contact your Agency Health Benefits Administrator. If after calling your Health Benefits Administrator you need more information, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.

HIPAA Privacy Authorization to Release Protected Health Information

By my signature below, I authorize the attending physician to provide my insurance carrier or health maintenance organization (HMO) with health information (to be indicated in Part D of this form) regarding the mental or physical disability of my dependent for whom I am requesting NYSHIP coverage. I also authorize the insurance carrier or HMO to disclose its determination (to be indicated in Part C of this form) to the Department of Civil Service. The purpose of these disclosures is to determine my dependent's eligibility for NYSHIP coverage and to implement that determination. I understand that I may revoke this authorization in writing at any time, as described in the NYSHIP Notice of Privacy Practices. Unless I revoke this authorization, this authorization will expire after my dependent's eligibility for coverage has been determined and implemented by the Department of Civil Service in its administration of the NYSHIP health plans. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected by HIPAA.

Enrollee's Signature	**Date**

PART B *(To Be Completed By Employing Agency)*

PLEASE PRINT OR TYPE

Effective Date Of Insurance For Dependent Above.	Previous Statement Submitted? ☐ Yes ☐ No	Was Dependent A Late Enrollment? ☐ Yes ☐ No

Enrollee's Health Insurance Coverage: ☐ Individual ☐ Family	Health Insurance Option ☐ Empire Plan ☐ HMO (write option and name) _____

Employing Agency	Agency Code	HBA Phone Number

I have reviewed the dependent information and have verified that the Dependent meets the eligibility requirements of the Program.

Authorized Signature	**Date**

PART C ***(To Be Completed By UnitedHealthcare or the Health Maintenance Organization)***

☐ Permanently Disabled	☐ Temporarily Disabled Through (Supply Date)	☐ Not Disabled	☐ Date Disability Started (Supply Date)
Signature			**Date**

PART D ***(To Be Completed By Attending Physician and mailed by the enrollee or attending physician to the appropriate carrier)***

Empire Plan Enrollees Mail To:
UnitedHealthcare
PO Box 1600
Kingston, New York 12402-1600

HMO Enrollees Mail To:

Mail this form directly to your HMO.

Physician's Name *(Print)* M.D.	**Physician's Address**
Enrollee's Name *(Print)*	Health Insurance ID Number
Dependent's Name *(Print)*	
Is this Dependent incapable of self-support by reason of physical or mental health disability? ☐ Yes ☐ No	

Date dependent became incapable of self-support.	Estimated duration of disability.	Date of your most recent examination of this patient.

Complete description of medical condition, including diagnosis, prognosis, current status and service being received:

If more space is necessary, attach additional pages.

PLEASE NOTE: Unless all questions are answered completely, a determination cannot be made.

Physician's Signature	**Date**

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Department of Civil Service
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EMPLOYEE BENEFITS DIVISION

Statement of Disability

Dependent 19 Years of Age or Older

PS-451I (4/10)

Health insurance benefits in the New York State Health Insurance Program (NYSHIP) are available for an enrollee's unmarried dependent children age 19 or older who are incapable of supporting themselves because of a mental or physical disability acquired before termination of their eligibility for health insurance, as described below.

Health insurance benefits in the New York State Heath Insurance Program (NYSHIP) are available for an enrollee's dependent children as described under the following circumstances:

1. The enrollee's own, legally adopted (including children in a waiting period prior to finalization of adoption) and dependent stepchildren under age 19;

2. The enrollee's "other" dependent children who reside permanently with the enrollee *and* receive more than 50 percent of their support from the enrollee, including medical expenses under age 19, **You must also complete a PS-457 Statement of Dependence to establish "other" dependent children's eligibility for NYSHIP**;

3. The enrollee's dependent child who is covered as a full-time student between the ages of 19 and 25. Up to four years may be deducted from the dependent student's age for documented service in a branch of the US Military.

Any expenses incurred for the attending physician's statement on the PS-451 Statement of Disability are the responsibility of the enrollee or dependent and are not considered a covered medical expense. See your General Information Booklet for additional information and for whom to contact, if you have questions.

Approval for enrollment in NYSHIP is contingent upon continuance of the enrollee's Family Coverage under the New York State Health Insurance Program. The employing agency or the Employee Benefits Division will notify the enrollee of the coverage determination.

Note: The employing agency for retirees, vestees, dependent survivors, enrollees covered under Preferred List provisions and COBRA enrollees of New York State Government and Participating Employers is the Employee Benefits Division of the Department of Civil Service. For enrollees either currently or formerly employed by a Participating Agency, that agency is the employing agency, regardless of the enrollee's status.

INSTRUCTIONS FOR COMPLETING THE PS-451 STATEMENT OF DISABILITY

1. **Enrollee** completes **Part A**.
2. **Employing Agency** completes **Part B**, (Parts A and B must be completed before any other parts of the form are completed to ensure confidentiality of the Dependent's medical information).
3. Leave **Part C blank** (see step 6)
4. **Attending Physician** completes **Part D** (attending physician cannot complete this section until Parts A and B are complete).
5. **Enrollee** or **Attending Physician** mails the completed form to the appropriate carrier:

Empire Plan Enrollees Mail To:	**HMO Enrollees Mail To:**
UnitedHealthcare PO Box 1600 Kingston, New York 12402-1600	Mail this form directly to your HMO.

6. If mental health specialist input is required for an Empire Plan enrollee, UnitedHealthCare may forward the PS-451 to OptumHealth. United HealthCare, the HMO or OptumHealth completes **Part C** and mails only Page 1 of the PS-451 to the Employee Benefits Division at the above address.