If your eligible dependent child is incapable of self-sustaining support because of a mental or physical disability, you may be able to continue coverage for that dependent beyond the age when coverage would usually end.

NYSHIP Disabled Dependent Eligibility Criteria

To continue coverage for a disabled dependent child, the dependent must meet all of the criteria below.

1. **Dependent Eligibility**
   The dependent must be eligible for NYSHIP coverage as a dependent. See your *General Information Book* for more information on dependent eligibility. For "other" children who are also disabled, you must provide a completed and verified *NYSHIP Statement of Dependence for "Other" Children* (PS-457) establishing "other" dependent eligibility for NYSHIP along with this form.
2. **Disability**
   The dependent must be incapable of self-sustaining support due to a mental or physical disability that has been verified by a physician.
3. **Dependent Age**
   The dependent's disability must have begun before they would otherwise age out of NYSHIP coverage:

   Medical Coverage
   The disability must have begun prior to the end of the month of the child's 26th birthday.

   Dental and Vision Coverage
   The disability must have begun prior to the child's 19th birthday (26th birthday for SEHP Enrollees) or while a full-time student between the ages of 19 and 25.

   If the child is incapable of self-sustaining support because of a disability that began while the child was a full-time student after turning age 25, up to four years may be deducted from the dependent student's age for documented service in a branch of the U.S. Military between 19 and 25. If your dental and vision coverage is through a Union Benefit Fund for dental and/or vision, you must contact your Union Benefit Fund directly for information regarding your dependent's eligibility.
4. **Marital Status**
   The dependent must be unmarried.

INSTRUCTIONS FOR COMPLETING THE NYSHIP STATEMENT OF DISABILITY FOR DEPENDENTS FORM PS-451

1. The ENROLLEE completes their portion of the form (the top section of page 2) and ***provides pages 2 and 3 to the treating physician.***

2. The PHYSICIAN completes their portion of the form (page 3). Once complete, the Enrollee or the physician **sends *pages 2 and 3 to the appropriate plan administrator (The Empire Plan or NYSHIP HMO).***

3. The PLAN ADMINISTRATOR completes their portion (the bottom of page 2) and ***mails page 2 to:***

THE DEPARTMENT OF CIVIL SERVICE
EMPLOYEE BENEFITS DIVISION
ALBANY NY 12239

Please note that while the plan administrator is reviewing the information, they may reach out to the enrollee or the treating physician for more information.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE BENEFITS DIVISION
NYSHIP Statement of Disability for Dependents
PS-451 (9/2020 L)

Enrollee Portion

Complete this portion of the form and then submit pages 2 and 3 pages to the treating physician.
Keep a copy of the completed form for your records.

Enrollee Information			
Enrollee Last Name	First Name		MI
Health Insurance ID number	Social Security Number	Phone Number	
Home Address	City	State	Zip Code

Dependent Information			
Dependent Last Name	First Name		MI
Date of Birth	Social Security Number	Is the dependent married? ☐ Yes ☐ No	
Relationship to the Enrollee: ☐ Natural/Adopted Child ☐ Stepchild ☐ Child of Domestic Partner ☐ 'Other' Child *(PS-457 NYSHIP Statement of Dependence is also required)*			
Percentage of support provided by the enrollee: _____%		Is the dependent employed? ☐ Yes ☐ No	
Is the dependent currently enrolled in Medicare Parts A & B? ☐ Yes ☐ No			

Personal Privacy Protection Law Notification

The information you provide on this application is requested in accordance with Section 163 of the New York State Civil Service Law for the principal purpose of enabling the Department of Civil Service to process your request concerning health insurance coverage. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by the Director, Employee Benefits Division, Department of Civil Service, Albany, NY 12239; (518) 473-1977. For information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

HIPAA Privacy Authorization to Release Protected Health Information

By my signature below, I authorize the attending physician to provide my plan administrator or health maintenance organization (HMO) with health information (to be indicated in the Physician Portion of this form) regarding the mental or physical disability of my dependent for whom I am requesting NYSHIP coverage. I also authorize the plan administrator or HMO to disclose its determination (to be indicated in the Plan Administrator Portion 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. 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**

Plan Administrator Portion

This portion of the form is to be completed by the appropriate plan administrator (UnitedHealthcare for The Empire Plan or the appropriate NYSHIP Health Maintenance Organization). Once complete, send this page only to: The Department of Civil Service, Employee Benefits Division (EBD), Albany, NY 12239 or by secure fax to 518-485-5590

Disabled: ☐ Yes ☐ No	Date the Disability Began:	Disability Certified Through: (*Maximum 7 years per certification*)
Plan Administrator: ☐ The Empire Plan (UnitedHealthcare) ☐ NYSHIP HMO - Code ☐ Name: _____		
Authorized Representative Signature: _____ Date: _____		

Physician Portion

All boxes below to be completed by the Treating Physician. Once complete, all pages must be sent to the appropriate plan administrator (Empire Plan or HMO) by the Enrollee or the Treating Physician.

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

Physician's Name		Physician's Phone Number
Physician's Address	City	State Zip Code
Patient Name		Health Insurance ID Number

Is this Dependent incapable of self-sustaining support by reason of physical or mental health disability? ☐ Yes ☐ No

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

Please provide a complete description of the patient's medical condition, including diagnoses, prognosis, current status, services being received and the specific deficit, impairment or disorder that renders the patient incapable of self-sustaining support.

(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: _____