



**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: _____	Name: _____
Social Security Number (SSN): _____ - _____ - _____	Social Security Number (SSN): _____ - _____ - _____
Address: _____	Address: _____
Telephone: ( ) _____	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.

<b>MEMBER QUESTIONNAIRE</b>			
			<b>Health Insurance</b>
1.	Yes	No	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.)
			Other insurance? (If yes, specify the plan name and type of coverage.)
			<b>Income and Support</b>
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.	Yes	No	Is the dependent entitled to receive:
	Yes	No	Social Security Disability Insurance (SSDI)? If yes, as of what date? _____
			Supplemental Security Income (SSI)? If yes, as of what date? _____
			<b>Additional Eligibility Questions</b>
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 Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

## Information Purpose

The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used for administration of Board 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 comply may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

## Social Security Numbers

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/ employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

## Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

## Your Rights

You have the right to review your membership files maintained by the System. For questions about this notice, our Privacy Policy, or your rights, please write to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call us at **888 CalPERS** (or **888-225-7377**).