Si necisita una versión de este documento en español, por favor llame al Departamento de Servicios a la Membresía al (505) 923-5678 o gratis al 1-800-356-2219.

DEPENDENT ELIGIBILITY DISABLED STATUS QUESTIONNAIRE

INSURED: ____________________________

ID #: _________________________________

GROUP #: ____________________________

EFFECTIVE DATE: ____________________

RE: _________________________________ DOB: _______________

1. Does this member reside with you at all times? _____________ If not, please explain.
   ____
   ____
   ____

2. Do you claim this member as a Dependent on your Federal Income Tax?_______
   Please send a copy of your last year's tax return and the Dependent's tax return if filed Separately.

3. Has this member been employed anytime within the last twelve (12) months?______
   If yes please explain.
   ____
   ____
   ____

4. Is this member receiving Medicaid benefits or Medicare disability benefits?_______
   If so, please send a copy of any disability award.

5. Has this member been evaluated in the last twelve (12) months by a physician? Please send a copy of the latest evaluation made by a physician. If the Dependent has not been evaluated recently, PHP may request you have one done or ask for copies of medical records to retain on file

IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH PAGES TO THIS FORM.

____

INSURED'S SIGNATURE DATE