Department of Civil Service

ATTACHMENT 32
Statement of Disability
RFP entitled: "Healthcare Program Administrative Services Only (ASO)"

PS-451-ASO 4/2010)

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 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 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**