



COUNTY OF
Riverside
 HUMAN RESOURCES
2001 Winner IPMA Award for Excellence

MEMBER QUESTIONNAIRE FOR DISABLED DEPENDENT BENEFIT

MEMBER: COMPLETE ALL ITEMS, INCOMPLETE FORMS WILL BE RETURNED, CAUSING DELAY IN BENEFITS.

PART A: INFORMATION

Member Information

Dependent Information

Name: _____ Name: _____

Social Security Number (SSN): _____ Social Security Number (SSN): _____

Address: _____ Address: _____

Telephone: _____ Date of Birth: _____

PART B: MEMBER QUESTIONNAIRE

Please provide the following information about the dependent 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: Human Resources P.O. Box 1569 Riverside CA. 92502.

MEMBER QUESTIONNAIRE			
Marital Status			
1.	Yes	No	Is the dependent married or has her/she ever been married
Health Insurance and Health Care			
2.	Yes	No	Is the dependent entitled to:
	Yes	No	Medi-Cal? (if yes, attach a copy of the dependent's Medi-Cal card.)
	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.)
	Yes	No	Other Insurance? (if yes, specify the plan name and type of coverage.)
3.	Yes	No	Has the dependent received In-Home Supportive Services or in-home skilled nursing care in the past year?
Income and Support			
4.	Yes	No	Is the dependent economically dependent upon you for his or her support? (if yes, attach a list of the dependent's monthly living expenses that you provide including housing, food, medical, clothing, etc.)
5.	Yes	No	Is the dependent entitled to receive:
	Yes	No	Social Security Disability Insurance (SSDI)?
	Yes	No	Supplemental Security Income (SSI)?
6.	Yes	No	Does the dependent currently attend school? (If yes, specify the name of the school(s) and course(s) of study.)
Employment History			
7.	Yes	No	Has the dependent <u>ever</u> worked (including work through a sheltered workshop)? (if yes, attach the date(s) of employment and employer name(s) and address(es).)
8.	Yes	No	If yes, is the dependent working now?
9.	Yes	No	If the answer to question 7 or 8 is yes, attach proof of the dependent's earnings for the current calendar year (January to December) and the two previous years.

Part C: Certification

I hereby certify that, to the best of my knowledge, the above information is complete and correct.

Member's Signature _____

Date _____

PRIVACY INFORMATION

The Information Practices Act of 1977 and the Federal Privacy Act require the Health Plan to provide the following information pursuant to individuals who are asked to supply information. The information requested is collected pursuant to government code (Section 20000, et seq.) and will be used for administration 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 supply the information may result in the Health Plan being unable to perform its functions regarding your status. Portions of this information may be transferred to other governmental agencies (such as your employer, physician, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.)

You have the right to review your membership files maintained by the Health Plan. For questions concerning your rights under the Information Practices Act of 1977, please contact the County of Riverside Human Resources at (909) 955-3591.

The Health Plan requests each enrollee's Social Security account number on a voluntary basis. However, it should be noted that due to the use of Social Security account numbers by other agencies for identification purposes, the Health plan may be unable to verify eligibility for benefits without the Social Security number.

The Health Plan uses Social Security account numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification.
2. Coordination of benefits among health plan carriers.
3. Resolve member appeals/complaints/grievances.