



The Health Plan
 52160 National Road East
 St. Clairsville, Ohio 43950-9365
 Telephone: (740) 695-3585
 Toll Free: 1-800-624-6961
 www.healthplan.org

Handicap Status

Name of Dependent: _____

Health Plan I.D.#: _____

SECTION 1 - TO BE COMPLETED/SIGNED BY THE SUBSCRIBER:

"I certify that my dependent listed above is unmarried and dependent upon me for support due to mental retardation or physical disability or handicap."

Subscriber's Signature: _____

Date: _____

(Please attach a copy of your most current tax return to verify your financial support for this dependent.)

SECTION 2 - TO BE COMPLETED/SIGNED BY THE PHYSICIAN:

"I certify that the dependent listed above is both incapable of self-sustaining employment by reason of mental retardation or physical disability or handicap which commenced on (date) _____."

Certifying Physician's Signature: _____

Date: _____

(Please attach written documentation or medical records which will support your assessment. This documentation should state the handicap as well as indicate its probable duration.)

enc/c: File

Attn: The Enrollment Services Department