State of Maryland
State Employee/Retiree Health Benefits Program
Disability Form

This portion to be completed by Employee/ Retiree.

Employee/Retiree Name:	Employee/Retiree Social Security Number:
Dependent's Name:	Dependent's Date of Birth:
	Month _____ Day _____ Year _____
Dependent's Sex: ☐ Male ☐ Female	Relationship to Employee/Retiree:
Dependent's Social Security Number:	**Dependent's Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated

Do you chiefly provide the dependent's support? ☐ Yes ☐ No

Is this dependent a current SSI recipient due to disability? ☐ Yes ☐ No

(Please enclose letter of determination from SSI)

Does this dependent have Medicare A or Part B? ☐ Yes ☐ No

Effective date: _____

(Please enclose Medicare letter)

Signature of Employee/Retiree _____ Date _____

This portion to be completed by Physician.

This portion outlines documentation to be submitted by the dependent's personal physician. Information must be current (i.e. the patient has been examined within the last 6 months for medical or 3 months for mental health.

Diagnosis: _____ Date of onset of condition: _____

Prognosis: _____

Does this condition impose on the dependent's ability to perform daily duties or maintain gainful employment?

☐ Yes ☐ No

Is the dependent in an institution? ☐ Yes ☐ No

Name of Institution: _____

Name of Physician (please print) _____ Phone Number _____

Physician's Address _____

_____

Signature of Physician _____ Date _____

For medical disability request, please attach the most recent history and physical, which document the diagnosis and the functional limitations.

For mental health disability request, please attach the most recent psychiatric evaluation which documents the diagnosis and the functional limitations

All Protected Health Information provided by your dependent's physician will be kept confidential in accordance with the HIPAA law and will only be reviewed for the purpose of determining your dependent's disability.

Once this form and medical notes are received along with the signed authorization form, we will forward all documentation to the medical plan for a determination. Please allow 30 days.