Baltimore City Public Schools
Office of Benefits Management
200 E North Ave Room 110
Baltimore, MD 21202
Phone 443.984.2000 Fax 410.545.0897

DISABLED DEPENDENT WAIVER REQUEST

Certification of disability is required for the Dependent to:

- Enroll in health plan
- Continue to be enrolled in health plan
- Remain enrolled in health plan after reaching age nineteen (19)

[ ] **Employee** ______________________________
Last, First, Middle

[ ] **Retiree** ______________________________
Last, First, Middle

Employee ID # ______________________________

Address ______________________________

Phone # ______________________________

Health Plan ______________________________

Dependent Name ______________________________

Date of Birth ______________________________

Social Security # ______________________________

Address ______________________________

[ ] Yes [ ] No Dependent has Medicare Part A Medicare No. ______________ Effective Date ______________
[ ] Yes [ ] No Dependent has Medicare Part B Medicare No. ______________ Effective Date ______________

I hereby authorize the following information to be released by the attending physician.

Signature ______________________________ **Date** ______________

PHYSICIAN USE ONLY

Physician Name ______________________________

Address ______________________________

Diagnosis ______________________________

Prognosis ______________________________

Date of Inception ______________________________

[ ] Yes [ ] No Condition precludes any substantial gainful work
[ ] Yes [ ] No Dependent is in an institution

Institution Name ______________________________

Admission Date ______________________________

Physician Signature ______________________________