State of New York
Department of Civil Service
The State Campus
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION

INSTRUCTIONS for the Statement of Disability Form (PS-451)

Dependent 19 Years of Age or Older

PS-451I (6/02L)

Health insurance benefits in the New York State Health Insurance Program (NYSHIP) are available for an enrollee's disabled dependent children as described below. The enrollee's dependent child who is covered as a full-time student between the ages of 19 and 25 and is disabled or becomes disabled while a covered full-time student or disabled before the 19th birthday is also eligible to apply for disabled dependent status.

Health insurance benefits in the New York State Heath Insurance Program (NYSHIP) are available for an enrollee's dependent children as described under the following circumstances:

1. The enrollee's own, legally adopted (including children in a waiting period prior to finalization of adoption) and dependent stepchildren who are unmarried, age 19 or older, who are incapable of self-support by reason of a mental or physical disability incurred before termination of enrollment in NYSHIP are eligible.

2. The enrollee's "other" dependent children who are age 19 or older are also eligible, if they are incapable of self-support by reason of a mental or physical disability, reside permanently with the enrollee *and* receive more than 50 percent of their support from the enrollee, including medical expenses.

You must also complete a PS-457 Statement of Dependence to establish "other" dependent children's eligibility for NYSHIP.

Any expenses incurred for the attending physician's statement on the PS-451 Statement of Disability are the responsibility of the enrollee or Dependent and are not considered a covered medical expense. See your General Information Booklet for additional information and for whom to contact, if you have questions.

Approval for enrollment in NYSHIP is contingent upon continuance of the enrollee's Family Coverage under the New York State Health Insurance Program. The employing agency or the Employee Benefits Division will notify the enrollee of the carrier's or HMO's determination.

Note: The Employee Benefits Division of the Department of Civil Service is the employing agency for retirees, vestees and dependent survivors, enrollees covered under Preferred List provisions and COBRA enrollees of New York State Government and Participating Employers. For enrollees either currently or formerly employed by Participating Agencies, the employer is the employing agency, regardless of the enrollee's status.

INSTRUCTIONS FOR COMPLETING THE PS-451 STATEMENT OF DISABILITY

1. **Enrollee** completes **Part A.**
2. **Agency** completes **Part B**, (Parts A and B must be completed before any other parts of the form are completed to ensure confidentiality of the Dependent's medical information).
3. Leave **Part C blank**
4. **Enrollee** completes **Part D.**
5. **Attending Physician** completes **Part E** (attending physician cannot complete this section until Parts A, B and D are complete).
6. **Enrollee** or **Attending Physician** mails the completed form to:

Empire Plan Enrollees Mail To:	**HMO Enrollees Mail To:**
United HealthCare Administrator for Metropolitan Life Insurance Company CPO Box 1600 Kingston, New York 12402-1600	Mail this form directly to your HMO.

State of New York
Department of Civil Service
The State Campus
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION

Statement of Disability

Dependent 19 Years of Age or Older PS-451 (6/02L)

PART A *(To Be Completed By Enrollee)*

Enrollee's Name *(Print)*		Health Insurance ID Number
Home Address *(No. and Street)*	City	State Zip Code

Dependent Information	Relationship (check one): ☐ Son ☐ Daughter ☐ Other Child*	
Dependent Name	Dependent Social Security Number	Dependent's Date of Birth

Personal Privacy Protection Law Notification

The information you provide on this application is requested for the principal purpose of enabling the NYS Department of Civil Service to process your request to continue enrollment for a disabled dependent 19 years of age or older in the New York State Health Insurance Program, State Administered Dental Program, State Administered Vision Program, and/ or Employee Benefit Fund Program. The 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 prevent the Department from processing this application. This information will be maintained by the Director, Division of Employee Benefits, NYS Department of Civil Service, The State Campus, Albany, NY 12239. For information related only to the Personal Privacy Protection Law, call (518) 457-9375. **For information, related to the Eligibility of Disabled Dependents, contact your Agency Health Benefits Administrator. If, after calling your Health Benefits Administrator, you need more information concerning coverage for Disabled Dependents, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.**

I request continuation of health insurance coverage for the above 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.

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	

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 United Healthcare or The Health Maintenance Organization)*

☐ Permanently Approved	☐ Temporarily Approved Through (Give Date) _____	☐ Disapproved
Signature		**Date**

State of New York
Department of Civil Service
The State Campus
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION

Statement of Disability

Dependent 19 Years of Age or Older

PS-451 (6/02L)

PART D *(To Be Completed By Enrollee)*

Dependent Questionnaire

Is Dependent presently employed? ☐ Yes ☐ No Is yes, explain:	Is Dependent married? ☐ Yes ☐ No	Percent of support provided by enrollee: _____ %

☐ Check if Dependent is permanently residing in your household and residence began prior to the age coverage would terminate.
If otherwise, explain:

Was this Dependent confined in a hospital or other institution on the date your insurance became effective? ☐ Yes ☐ No

Was this Dependent confined at home and under the care of a physician for the disabling condition on the date insurance became effective? ☐ Yes ☐ No
(If confined at home, use attached sheets to give details. To what extent were Dependent's activities restricted to your home?)

Was Dependent released from such confinement or physician's care? ☐ Yes ☐ No

If so, give date _____

Explain:

(Use additional pages if necessary)

PART E *(To Be Completed by Attending Physician)*

Physician's Name M.D.	**Physician's Address**

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**