Health Account Services
P.O. Box 942715
Sacramento, CA 94229-2715
(888) CalPERS (or **888**-225-7377)
TTY (877) 249-7442
Fax (800) 959-6545

MEMBER QUESTIONNAIRE for the CalPERS DISABLED DEPENDENT BENEFIT

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

PART A: **MEMBER INFORMATION:**	**DEPENDENT INFORMATION:**
Name: _____ **Social Security Number (SSN):** _____-_____-_____ **Address:** _____ **Telephone:** (____)_____	**Name:** _____ **Social Security Number (SSN):** _____-_____-_____ **Address:** _____ **Date of Birth:** _____

PART B: Please provide the following information about the dependent who is seeking initial or continued enrollment or recertification in the health plan 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 the above address.

MEMBER QUESTIONNAIRE			
			Marital Status
1.	**Yes** ☐	**No** ☐	Is the dependent married or has he or she ever been married? If yes, do not complete the remainder of this form. The dependent is **NOT** eligible to continue enrollment in the CalPERS Health Benefit Program.
			Health Insurance and Health Care
2.			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, clothing, medical, etc.)
5.			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 *ever* 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** ☐	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 Name Date

PRIVACY INFORMATION

The Information Practices Act of 1977 and the Federal Privacy Act require the California Public Employees' Retirement System (CalPERS) to provide the following information to individuals who are asked to supply information. The information requested is collected pursuant to the Government Code Sections (20000. et seq.) and will be used for administration of the Board's duties 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 System being unable to perform its functions regarding your status. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians, 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 System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, P.O. Box 942702, Sacramento, CA 94229-2702.

Section 7(b), of the Privacy Act of 1974 (Public Law 93—579) requires that any federal, state, or local governmental agency which requests an individual to disclose his Social Security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it.

Health Account Services of the California Public Employees' Retirement System 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, Health Account Services may be unable to verify eligibility for benefits without the Social Security account number.

Health Account Services of the California Public Employees' Retirement System uses Social Security account numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and state contribution for state employees
3. Billing of contracting agencies for employee and employer contributions
4. Reports to the California Public Employees' Retirement System and other state agencies
5. Coordination of benefits among carriers
6. Resolve member appeals/complaints/grievances with health plan carriers