**58856-****{stdMbrPERSLinkID}**



**APPLICATION FOR DEPENDENT DISABILITY**

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 58856 (Rev. 01-2014)

**NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657**

**(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920**

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| PART A SUBSCRIBER IDENTIFICATION | |
| Name (Last, First, Middle) {stdMbrFullNameLFM} | NDPERS Member ID {stdMbrPERSLinkID} |
| Last Four Digits of Social Security Number {stdMbrLastFourDigitsOfSSN} | Date of Birth {stdMbrDateOfBirth} |
| Organization Name {stdCurrentEmployerOrgName} | NDPERS Organization ID {stdCurrentEmployerOrgCodeID} |
| **PART B SUBSCRIBER STATEMENT** | |
| 1. Does dependent reside at the home of the subscriber? Yes No  If not, why? (ie. divorce decree, group home, residential facility): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2. Is the dependent claimed on the subscriber’s federal tax income return? Yes No  3. Is the dependent unmarried? Yes No  4. Is the dependent capable of ANY employment? Yes No  If yes, is the dependent employed? Yes No  Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Job Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Number of Hours per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Method of transportation to and from job (drives car, uses public transportation, uses special van (ie. “Handiwheels”, etc). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  5. Does dependent have a diagnosis of mental retardation? Yes No  6. Does dependent have a diagnosis of physical disability? Yes No  7. Does dependent have a diagnosis of any seizure disorder? Yes No  If yes, when was the last seizure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medication, dose and frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Number of seizures per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  8. Does dependent attend school? Yes No  Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What grade level? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mainstream (in non special education class) experience: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  9. Is dependent blind and/or deaf? Yes-Blind Yes-Deaf No  If yes, does/did the dependent attend special education for the disability? Yes No | |

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| 10. Was the dependent born with the disability? Yes No  11. Was the disability acquired? Yes No  Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  12. What is the dependent’s level of activity for Activities of Daily Living (ADL’s)?  Needs complete assistance in feeding, dressing, etc.  Needs partial assistance in feeding, dressing, etc.  Needs mental cueing to do activity.  Needs assistance for mobility, does most ADL’s independently (ie. needs assist to wheelchair, car, bed).  13. What is the expected date of improvement in condition or recovery?  Disability is considered permanent.  Disability is of a nature that dependent status MIGHT change after sufficient education, and training.  Disability is of a nature that dependent status WILL change after sufficient education, and training. |
| **PART C SUBSCRIBER AUTHORIZATION** |
| I have read this application in its entirety and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any benefit plans insured based on this application.  Subscriber Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Return this form, with a completed “Physician Form for Handicapped Dependent SFN 58798”, to the address listed at the top of this form.