PROOF OF DISABLED CHILD

PLEASE COMPLETE ONE FORM PER CHILD

Employer Information	Name of Your Employer	Group number as shown on your ID Card
Employee Information	Last Name First Name MI	Employee's Social Security Number
	Home Address	Employee's Birth Date Month Day YR
	City State Zip	Marital Status: Single ☐ Married ☐ Divorced ☐
Disabled Child's Information	Last Name First Name MI	Child's Birth Date Month Day YR
	Child's age when disability occurred	Is child dependent on you for support? Yes ☐ No ☐ If **Yes**, what percentage %
	Is the child listed a your dependent on your last years Federal Income Tax return? Yes ☐ No ☐	Is the child permanently residing in your household? Yes ☐ No ☐. If No, why not?
	Nature of disability	
Complete if Child is covered under any other health plan	Name of Policyholder	
	Other Group Plan Name	Identification / Policy Number
	Insurance Company Name and Address	
	City State Zip	

To be completed by the Employer	Please correct and initial (if changes made) all of the information given by the employee that does not agree with your records.		
	Effective date of Employees insurance Month Day YR	Effective date of Dependent's insurance Month Day YR	Has coverage terminated? Yes ☐ No ☐
	Authorized representatives signature		Date Month Day YR

Authorization to release medical and insurance information

To any physician, medical practitioner, hospital, clinic or other medically related facility or provider of medical services or supplies, and any employer, group policyholder, or contract holder or insurer, I authorize you to release to TRISTAR Benefit Administrators, Inc. or to its representatives any and all information you may have about the mental and physical history, condition and treatment, and insurance coverage for the child named above.

I understand the information obtained by TRISTAR Benefit Administrators, Inc. will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by TRISTAR Benefit Administrators, Inc. to any person or organization EXCEPT to reinsuring companies, Group Policyholder, or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required or as I may further authorize. For the purpose of disclosing information, I understand that this authorization is valid for a period of one year. I know that I may request a copy of this authorization. If this authorization is given in connection with a claim for health benefit, disability, or life insurance benefits, I understand that it is valid for the duration of the claim. A photocopy of this authorization shall be as valid as the original.

I verify the above information is true and accurate.

Employee's Signature	Date Month Day YR

OPPOSITE SIDE TO BE COMPLETED BY ATTENDING PHYSICIAN

TRISTAR Benefit Administrators
PO Box 65887
West Des Moines, IA 50265

TBAeligibility@tristargroup.net

TO BE COMPLETED BY ATTENDING PHYSICIAN

Note…. Any fee for the completion of this form is the responsibility of the employee.

Patients Information	Patients Name	Patient's Birth Date Month Day YR
Diagnosis	Patient's Diagnosis (Please be as detailed as possible)	
Treatment	Date of first visit Month Day YR	
	Frequency of visits Weekly ☐ Monthly ☐ Other ☐	
	When did you last treat the patient? Month Day YR	
	Nature of treatment	
Extent of Disability	Is patient now incapable of self-support because of the disability? Yes ☐ No ☐	
	Limitation(s) causing disability	
	Has such disability existed continuously since before the patient reached age 19? Yes ☐ No ☐	
	When do you think the patient will be able to return to gainful employment? Approximate date: Month Day YR Infinite ☐ Never ☐	
Physician's Information	Name of Physician	Telephone Number
	Address of Physician	
	Physician's Signature	Date Month Day YR

TRISTAR™
BENEFIT ADMINISTRATORS