Nassau Community College Federation of Teachers Trust Fund / Statement of Disability
(dependent 19 years of age or older)

PART A *(To be Completed By Enrollee. Keep a copy of the completed form for your records.)*

Enrollee's Name *(Print)*	Social Security Number:	Enrollee's Phone Number
Home Address *(No. and Street)*	City	State / Zip Code

I request continuation of Dental coverage for the below named Dependent who is disabled and incapable of self-support.

Dependent Information	Relationship *(check one)* ☐ Son ☐ Daughter ☐ Other Child*

Dependent's Name	Dependent's Social Security Number	Dependent's Date of Birth

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

Is disabled dependent enrolled in Medicare A & B ? ☐ Yes ☐ No If yes, provide a copy of dependent's Medicare Card.

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

Personal Privacy Protection Law Notification

The information you provide on this application is requested for the principal purpose of enabling the trustees of the HHHTA Welfare Trust Fund to process your request to continue enrollment for a disabled dependent 19 years of age or older in the HHHTA Welfare Trust Fund, Dental Program, Excess Major Medical/Vision Program, and/or other employee benefit fund programs. The information will be used in accordance with Section 96 (1) of the Public Officers Law, also known as the Personal Privacy Protection Law. Failure to provide the information requested may prevent the Welfare Fund Trustees from processing this application.

HIPPA Privacy Authorization to Release Protected Health Information

By my signature below, I authorize the attending physician to provide my insurance carrier or the Administrator of the HHHTA Welfare Trust Fund with health information (to be indicated in Part D of this form) regarding the mental or physical disability of my dependent for whom I am requesting Dental coverage. The purpose of these disclosures is to determine my dependent's eligibility for dental coverage and to implement that determination. I understand that I may revoke this authorization in writing at any time, as described in the HHHTA Notice of Privacy Practices. Unless I revoke this authorization, this authorization will expire after my dependent's eligibility for coverage has been determined and implemented by the Administrator and Trustees of the HHHTA Welfare Trust Fund in its administration of the Dental Plan. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected by HIPAA.

Employee's Signature	Date

PART B *(To be Completed By the NCCFT Trust Administrator)*

Effective Date of Insurance for Dependent Above.	Previous Statement Submitted? ☐ Yes ☐ No	Was Dependent A Late Enrollment? ☐ Yes ☐ No

Employee's Health Insurance Coverage: ☐ Individual ☐ Family	Health Insurance Option: ☐ Empire Plan ☐ HMO (write option and name)

Employing Agency	Benefit Type	Trust Fund Phone Number

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 the NCCFT Trust Administrator)*

☐ Permanently Disabled	☐ Temporarily Disabled Through *(Supply Date)*	☐ Date Disability Started *(Supply Date)*

Signature	Date

PART D ***(To be Completed By Attending Physician and mailed by the enrollee or attending physician to the appropriate carrier indicated below)***

☐ **NCC Federation of Teachers**
One Education Drive Bldg. F - Room 3293
Garden City, NY 11530

☐ **Newman Company**
925 Hempstead Tpke. Suite 340
Franklin Square, N.Y. 11010

Physician's Name (*Print*) M.D.	**Physician's Address**
Enrollee's Name (*Print*)	**Health Insurance ID Number**
Dependent's Name (*Print*)	
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.

Signature	**Date**