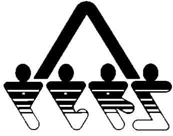

APPLICATION FOR DEPENDENT DISABILITY

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 58856 (Rev. 12-2009)

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A SUBSCRIBER IDENTIFICATION	
Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth
Organization Name	NDPERS Organization ID

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.