



APPLICATION FOR DEPENDENT DISABILITY
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 58856 (Rev. 01-2014)

58856

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? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, why? (ie. divorce decree, group home, residential facility): _____
2. Is the dependent claimed on the subscriber's federal tax income return? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is the dependent unmarried? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is the dependent capable of ANY employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the dependent employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does dependent have a diagnosis of physical disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Does dependent have a diagnosis of any seizure disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was the last seizure? _____ Medication, dose and frequency: _____ Number of seizures per day: _____
8. Does dependent attend school? <input type="checkbox"/> Yes <input type="checkbox"/> No Where? _____ What grade level? _____ Mainstream (in non special education class) experience: _____
9. Is dependent blind and/or deaf? <input type="checkbox"/> Yes-Blind <input type="checkbox"/> Yes-Deaf <input type="checkbox"/> No If yes, does/did the dependent attend special education for the disability? <input type="checkbox"/> Yes <input type="checkbox"/> 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.