



Department of the Navy
Civilian Benefits Center

Certification for Child
Incapable of Self-Support

INFORMATION FOR THE ENROLLEE

- Federal Employees Health Benefits (FEHB) enrollments may include a child incapable of self-support because of a disability which existed before age 26.
- Federal Employees' Group Life Insurance (FEGLI) Program, and/or Federal Dental and Vision Insurance Program (FEDVIP) enrollments may include a child incapable of self-support because of physical or mental incapacity which existed before age 22.
- Title 5 CFR 890.302(d) requires that the enrollee submit a physician's certificate verifying the child's disability. Medical certificates may be submitted when you first enroll or 60 days before the child reaches age 26 for FEHB and before age 22 for FEGLI and/or FEDVIP.

Please give this form to your child's physician to complete. After it has been completed, you may fax it to 207-255-0131; however, you must also mail the original to the following address:

Human Resources Benefits Contact Center
P. O. Box 590
Machias, ME 04654

If you have questions please call the Benefits Line at 888-320-2917 and select menu option #4 to speak with a Customer Service Representative (CSR). CSRs are available from 7:30 a.m. until 7:30 p.m., Eastern Time, Monday through Friday, except on federal holidays. The TTY number for the deaf and hard of hearing is 866-359-5277. You may also email your questions to navybenefits@navy.mil.

Certification and Consent for Release of Information

I certify that my child (check all that apply):

- ☐ Is certified by a state or federal rehabilitation agency as unemployable;
- ☐ Is receiving: (a) benefits from Social Security as a disabled child; (b) survivor benefits from the Civil Service Retirement System or Federal Employees Retirement System as a disabled child; or (c) benefits from Office of Workers Compensation Program as a disabled child;
- ☐ Is confined to an institution because of impairment due to a medical condition; treatment, rehabilitation, educational training or occupational accommodation has not and will not result in a self-supporting individual;
- ☐ Requires total supervisory, physical assistance, or custodial care;
- ☐ Is employed but the income is less than the equivalent of the GS 5, step 1.
- ☐ Is included on my income tax return.

I authorize the release of information so that the Civilian Benefits Center can make a self-support determination regarding my child for the purpose of coverage as a family member.

Enrollee's Name (please print)

Last 4 digits of Enrollee's SSN

Signature

Date

Patient Information		
Child's Name:	Child's Date of Birth	Last 4 digits of Child's SSN
Attending Physician's Report		
Please complete this form for the Civilian Benefits Center to make a determination of incapacity of self-support for the child listed above.		
1. Diagnosis and history of the specific medical condition(s), references to findings from previous examinations, treatment and responses to treatment. Assessment of the current clinical status and plans for future treatment:		
2. Clinical findings from the most recent physical examination, including objective findings of physical examination, results of laboratory tests, x-rays, EKGs, and other special evaluations or diagnostic procedures, and, in the case of psychiatric disease, the findings of mental status examinations and the results of psychological tests:		
3. Assessment of degree to which the medical condition has become static or stabilized and an explanation of the medical basis for the conclusion.		
4. Probable future course and duration of disability, including an estimate of the expected date of full or partial recovery (give date of partial disability or write if it is a permanent disability).		
5. Is the child confined to an institution because of impairment due to a medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Does the child require total supervisory, physical assistance, or custodial care? <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Will treatment, rehabilitation, educational training, or occupational accommodation allow the child to be self-supporting? <input type="checkbox"/> Yes <input type="checkbox"/> No		
8. In your opinion, is the child incapable of self-support because of a physical or mental disability that began: Before the child became age 26? <input type="checkbox"/> Yes <input type="checkbox"/> No Before the child became age 22? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9. In your opinion, can the condition be expected to continue for more than one year? <input type="checkbox"/> Yes <input type="checkbox"/> No		
10. If the medical is not disabling, please comment if condition is not compatible with employment, that there is a medical reason to restrict the child from working or he/she may suffer injury or harm by working. Indicate if permanent or temporary with estimated length of possible recovery or need for reevaluation.		
Physician's Name	Address	Telephone Number
I certify that above information is accurate		
Physician's Signature		Date

WARNING**

This document may include material covered by the Privacy Act of 1974
and should be viewed only by personnel having an official
"need to know" the information contained herein.