For MPE Use Only:_____

Massachusetts Public Employees Fund
Vision and Dental Health Plans
Developmental Disability Form

SECTION I: To be completed by Fund Member

Member Name: _____Member ID Number:_____

Home Address:_____

City:_____ State:_____Zip Code:_____

Dependent's Name: _____Dependent's Date of Birth: _____

Dependent's Relationship to Fund Member:_____

Date Dependent Became Totally Disabled:_____

First Treatment of the Condition (Month/Year):_____

Most Recent Treatment of the Condition (Month/Year):_____

Presently Attending School:

☐ Yes Part-Time: (Hours Per Week):_____ Full-Time ☐

Name of School:_____

☐ No

Able to Work:

☐ Yes Presently Working At:_____Hours Per Week_____

☐ No If No, Why not?:_____

How does the condition prevent him/her from working?:_____

When last worked:_____Where last worked:_____

Description of Work:_____

Additional Required Information: The dependent listed must have been determine to be disabled under the Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). You must include a copy of the Award Letter dated within the last three (3) years with this form.

I attest to the accuracy of the information contained within this form and understand that the Massachusetts Public Employees Fund may need to obtain additional medical information for further review in determining eligibility status.

Signature of Member:_____ Date:_____

Section I and Section II of this form must be completed and returned with a copy of the SSI or SSDI Award Letter to:

Massachusetts Public Employees Fund
Enrollment Department
PO Box 3319
Peabody, MA 01961-3319

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Massachusetts Public Employees Fund
Vision and Dental Health Plans
Developmental Disability Form

SECTION II: To be completed by provider primarily responsible for treating the condition:

Patient name: _____

Date of first visit with patient:_____

Date of most recent visit with the patient:_____

Diagnosis:_____

To your knowledge, length of time this condition has existed:_____

Indicate date that the condition resulted in marked and severe functional limitations such that the dependent became unable to work, live or function independently on a daily basis. Please describe.

_____

_____

In your professional opinion, is this dependent described above physically and/or mentally capable of employment?

☐ Yes Please indicate how many hours per week:_____

☐ No If no, please describe:_____

In your professional opinion, does the condition appear to be:

☐ Permanent ☐ Temporary, length of time_____ ☐ No longer in evidence

I hereby attest under the penalties of perjury that the above information is true, based on my professional knowledge and belief.

_____ _____

Physician's Signature Date

Physician's Data

Name:_____

Office address:_____City:_____ State:_____ Zip:_____

Office telephone number:_____ Office fax number:_____

Physician's specialty:_____

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