Penn Medicine
Lancaster General Health

LG Health Disabled Dependent Form

My dependent named below has or will soon reach the maximum age of 26 for coverage under the Lancaster General Health Employee Benefit Plan and may qualify to remain on the plan due to a disability.

_____ _____
Dependent Name (First Name, Initial, Last Name) Birth Date (mm/dd/yyyy)

In order to complete our review to determine disability status under the Plan, please answer the following questions:

1. Is the dependent a disabled child, who lives with you and who is not able to support himself or herself because he or she is mentally or physically incapacitated? ___Yes ___No

2. Did the mental or physical incapacity begin prior to his or her reaching age 26? ___Yes ___No

I certify that the dependent named above is incapable of self-support and is primarily dependent upon me for maintenance and support (declared as a dependent for Federal Tax purposes).

Date: _____ Employee Signature:_____

Kindly respond as soon as possible to expedite claim processing. Thank you!
Please respond by answering the questions below mailing your response to the Human Resources - Benefits address listed below.

Penn Medicine Lancaster General Health
Human Resources - Benefits
1097 Commercial Avenue
East Petersburg, PA 17520

In addition, please forward the below Physician Questionnaire to the dependent's physician to complete.

Please note that both the Employee Statement and Physician Statement must be returned in order to determine benefits for the above named dependent.

Penn Medicine
Lancaster General Health

Dear Physician,

In order to complete our review to determine disability status please prepare the following information:

Section 1 – This section must be completed by the LG Health Employee

Dependent Name:
Dependent Birth Date (mm/dd/yyyy):

Section 2 – This section must be completed by the Dependent's Physician

- Copy of the assessment (and associated findings) that resulted in the diagnosis of disabled. (This may include results from any pertinent reference information such as medical or physical therapy records, labwork, etc.)
- Medical description of the extent/severity of the patient's condition.
- Provider's description of the limitations experienced by the patient with regard to activities of daily living (e.g. eating, dressing, ambulating).

Questions we will need to be able to answer based on the information you send include:

1. Please advise the date the patient became totally disabled
2. Is the disability temporary or permanent
3. Please advise the diagnosis along with subjective symptoms and objective symptoms
4. Please advise the date of the last treatment and/or visit
5. Please advise the frequency of the visits: Weekly, Monthly, Regressed
6. Please advise the type of treatment
7. Please advise if the patient is ambulatory
8. Please advise if the patient is house confined
9. Please advise if the patient is totally incapable of self-support
10. Please advise the date the patient can resume normal activities

Total Number of pages being sent: _____
Physician Name (please print): _____
Address: _____
Telephone Number: _____ Date: _____
Physician Signature: _____

We thank you for your cooperation in order to make a complete and thorough assessment. You may mail the requested information to the address below:

Penn Medicine Lancaster General Health
Human Resources - Benefits
1097 Commercial Avenue
East Petersburg, PA 17520

According to the Department of Labor guidelines, you have forty-five (45) calendar days to provide the information requested.