Commonwealth of Virginia
Adult Incapacitated Dependent Eligibility Verification Form
July 2023 Special Enrollment

Important Notice:

To consider enrollment for your dependent child as an adult incapacitated dependent (AID) under the Commonwealth of Virginia health benefits program, you must complete and return a health benefits enrollment form along with this eligibility verification form.

The forms and any supporting documentation must be returned *to: DHRM; Office of Health Benefits,101 N. 14th Street, Richmond, VA 23219, emailed to ohb@dhrm.virginia.gov or faxed to 804-371-0231.*

If the enrollment request is not **received by Tuesday, August 29, 2023,** you will have missed the opportunity for consideration to enroll your AID. This means that you will not be able to request a review for your AID unless there is a consistent qualifying life event as determined by the Office of Health Benefits.

If you have questions, please feel free to contact the Office of Health Benefits at ohb@dhrm.virginia.gov, 1-804-225-3642 or 1-888-642-4414.

To be completed by the Employee/Retiree Group Participant:

1.	Employee/Retiree name: ID Number:		
2.	Name of AID requiring eligibility verification:		
3.	What is the AID's date of birth:		
4.	Is the AID married?	☐Yes	☐ No
5.	Do you provide over one half of your AID's support?	☐Yes	☐No
6.	Does the AID reside at home, full-time, with you (the employee/retiree) as a member of your household? If the natural or adoptive parents live apart, living with the other parent will satisfy this requirement.	☐Yes	☐No
7.	If no, does the AID live in a facility? Please select one: ☐ Group Home ☐ Nursing Home/Convalescent Home ☐ Long-term Care Facility Name of Facility:_____ ☐ Other Please be specific:		
8.	Is the AID eligible for Medicare, Medicaid or other employer health plan?	☐ Yes	☐No
9.	Is the AID currently employed? If yes, provide a description of his/her employment:	☐Yes	☐No
10.	What is the date the disability began?		
11.	Has the AID been continuously covered on a parent's group employer coverage since the incapacitation first occurred, or as a Medicaid/Medicare recipient? If yes, provide proof of continuous coverage from age 26 to current.	☐ Yes	☐No

Employee/Retiree Signature:	Date Signed: