58798

PHYSICIAN'S FORM FOR DEPENDENT DISABILITY

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 58798 (Rev. 09-2024)

Clear Form

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
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Subscriber's Name (Employee)		NDPERS Member ID	
Date of Birth	Last Four Digits of Social Security Number	Today's Date	
Subscriber's Mailing Address	City	State	ZIP Code
Organization Name	NDPERS Organization ID		
Dependent's Name	Dependent's Date of Birth		

Please respond to the questions below in as complete a manner as possible. This information will assist the insurance provider in determining this patient's eligibility for continued insurance coverage as a dependent disability.

To Identify the Treating Physician

Physician Name		
Specialty		License Number
Address	Telephone Number	Fax Number

Diagnosis(es) (ICD-9)

1. How long have you treated this patient?

2. When did you last see this patient?

3. What is the degree of physical/mental impairment?

4. In your professional opinion, is this patient continuously incapable of self-sustaining employment due to a physical or mental disability?

☐ No ☐ Yes

If yes, please explain.

5. Based upon your understanding of the patient's medical history, how long has this patient been incapable of self-sustaining employment?

6. When, in your professional opinion, might this patient be capable of self-sustaining employment?

7. Is the individual trainable/educable?

Physician's Signature (Electronic Signature will not be accepted)	Date
Physician Printed Name	

Please send this form to your dependent's health care provider for completion.