American Airlines Statement of Dependent Eligibility Beyond Limiting Age

Due to Mental or Physical Disability

Employee Statement					**Answer all questions below. Omitted information will cause delays**		
Name (Print)	First	Middle	Last		Member ID:	Date of Birth	❑ Male ❑ Female
Present Address:	Street	City	State	Zip Code	Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced	Phone (Including Area Code) ( )	

Dependent Information

Name (Print)	First	Middle	Last		Date of Birth	❑ Male ❑ Female
Present Address:	Street City	State	Zip Code	Marital Status: ❑ Single ❑ Married	Relationship to Employee	
Name and address of dependent's current employer						
If not now employed, give date last employed	Estimated income of dependent from all sources $_____monthly	Percentage of support of dependent supplied by employee _____%		Is dependent permanently residing in employee's household? ❑ Yes ❑ No If No, Explain		
Is dependent listed as a dependent in your last Federal Personal Income Tax Return? ❑ Yes ❑ No If No, Explain						
Explanations						
. Employee Signature:					Date	

Physician Statement			**(Any fee for the completion of this statement is to be paid by the employee.) Answer all questions below. Omitted information will cause delays**	
Patient's Name	First	Middle	Last	Patient's Date of Birth
Is this dependent presently incapable of self-sustaining employment by reason of: Physical Disability? ❑ No ❑ Yes Mental Disability? ❑ No ❑ Yes Other (explain) ❑ No ❑ Yes			Date or Age at Onset of disability	Date dependent became incapable of self-sustaining employment.
Diagnosis of condition causing incapacity. If mental disability is present, give degree of disability. Please give date and report of surgery, X-rays, electrocardiograms, or other special tests. Explain how the member's condition prevents work/self-support. Use a separate sheet of paper if necessary.				
Does the patient have a job? ❑ Yes ❑ No				
Do you know what the patient's job is? ❑ Yes ❑ No			Do you know what duties the patient's job requires? ❑ Yes ❑ No	
Has this patient been able to do full or part-time work of any kind? ❑ No ❑ Yes, From_____Date			Will the patient be capable of self-support? ❑ No ❑ Yes, From_____Date	
The patient is presently (check one) ❑ Ambulatory ❑ Bed confined ❑ House confined ❑ Hospital confined				
Physician's/Surgeon's Name (Print)		Address	Phone (Including Area Code) ( )	
Physician signature:				Date

For Use by Administrator

Dependent eligibility will continue to	Month	Day	Year
Dependent eligibility declined. Give reason.			
Signature			Date

Please return this form to the Benefits Service Center once the Employee/Physician statement is complete:

AMERICAN AIRLINES
BENEFIT SERVICE CENTER
P O BOX 661052
Dallas, TEXAS 75266-1052
FAX: 847-554-1884