



**REQUEST FOR CONTINUATION  
 OF COVERAGE FOR  
 HANDICAPPED CHILDREN**

**PART I – EMPLOYEE STATEMENT**

EMPLOYEE'S NAME (Last, First, M.I.)		DATE OF BIRTH (M.D.Y)		TELEPHONE NUMBER	
EMPLOYEE'S ADDRESS (Street, City, State, Zip Code)				EMPLOYEE'S MEMBER NO. 	
CHILD'S NAME (Last, First, M.I.)		CHILD'S DATE OF BIRTH (M.D.Y)		CHILD'S RELATIONSHIP TO EMPLOYEE	
CHILD'S ADDRESS (Street, City, State, Zip Code)				CHILD'S SOCIAL SECURITY NO. (if applicable) 	
CHILD'S MARITAL STATUS	CHILD'S SEX <input type="checkbox"/> M <input type="checkbox"/> F	CHILD'S EDUCATION (CIRCLE) High School - 1 2 3 4 College - 1 2 3 4	CHILD'S VOCATIONAL TRAINING <input type="checkbox"/> Yes <input type="checkbox"/> No WHERE WHAT COURSE		
IS YOUR CHILD FULL-TIME STUDENT? IF YES, NAME AND ADDRESS OF SCHOOL: <input type="checkbox"/> Yes <input type="checkbox"/> No					
HAS YOUR CHILD EVER BEEN EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, GIVE NAME, ADDRESS AND DATES:					
IS YOUR CHILD COVERED UNDER ANOTHER GROUP INSURANCE OR GOVERNMENT PLAN SUCH AS MEDICARE, AN HMO PLAN OR AUTOMOBILE MANDATORY NO-FAULT COVERAGE WHICH WILL ALSO COVER ANY MEDICAL EXPENSES OR DISABILITY LOSSES? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, GIVE NAME OF INSURANCE COMPANY/ FIRST BENEFIT INSURER, ORGANIZATION, OR HMO PROVIDING BENEFITS					
NAME & ADDRESS				POLICY NUMBER	
IS THE CHILD DEPENDENT UPON YOU FOR SUPPORT? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, DESCRIBE SUPPORT				DOES CHILD QUALIFY AS A DEPENDENT ON YOUR FEDERAL TAX RETURN? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				AGE WHEN HANDICAP OCCURRED	
DESCRIBE YOUR CHILD'S HANDICAP:					
AUTHORIZATION TO RELEASE INFORMATION – I hereby authorize any Physician, Hospital, Dentist, Pharmacy, Insurance Company, Employer, or Organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment, or benefits payable, including disability or employment related information concerning this coverage to the Plan Administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with this child. This authorization or a photostatic copy of the original shall be valid and effective for one year from date of signature.					
EMPLOYEE SIGNATURE				DATE (M.D.Y)	

**PART II-EMPLOYER'S STATEMENT**

POLICYHOLDER, DIVISION, ADDRESS		ACCOUNT NUMBER OR POLICY NUMBER
EFFECTIVE DATE OF:	EMPLOYEE'S INSURANCE	CHILD'S INSURANCE
HAS COVERAGE BEEN CONTINUOUSLY IN EFFECT UP TO THE PRESENT DATE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF COVERAGE WAS NOT CONTINUOUS EXPLAIN:		
SIGNATURE OF EMPLOYER REPRESENTATIVE	TITLE	DATE (M.D.Y.)

**PLEASE NOTE: PART III, ON NEXT PAGE, TO BE COMPLETED BY PHYSICIAN**

**PART III – ATTENDING PHYSICIAN STATEMENT**

PATIENT'S NAME (Last, First, M.I.) ADDRESS (Street, City, State, Country, Zip Code/Postal Code)		DATE OF BIRTH (D.M.Y.)
WHEN DID SYMPTOMS FIRST APPEAR?	IQ TESTS: NAME:	RESULT:
SUBJECTIVE SYMPTOMS		
OBJECTIVE SYMPTOMS		
DATE FIRST CONSULTED FOR THIS CONDITION	DATE OF LAST VISIT (D.M.Y)	FREQUENCY OF VISITS
HOSPITAL CONFINEMENT DATES		
DIAGNOSIS: GIVE DIAGNOSIS OR ICD 9 CODE		
OTHER PHYSICAL DEFECTS, IF ANY:		
MEDICATIONS: TYPE AND DOSE		
FIRST DATE OF DISABILITY:		
WAS DISABILITY CONTINUOUS FROM THIS DATE TO PRESENT? <input type="checkbox"/> Yes <input type="checkbox"/> No IF NO, WHEN DID DISABILITY END?		
DEGREE OF: PHYSICAL IMPAIRMENT <input type="checkbox"/> NONE <input type="checkbox"/> MILD <input type="checkbox"/> SEVERE <input type="checkbox"/> PROFOUND	PSYCHIATRIC IMPAIRMENT <input type="checkbox"/> NONE <input type="checkbox"/> MILD <input type="checkbox"/> SEVERE <input type="checkbox"/> PROFOUND	
IS THE PATIENT : <input type="checkbox"/> AMBULTORY <input type="checkbox"/> HOUSE CONFINED <input type="checkbox"/> BED CONFINED <input type="checkbox"/> HOSPITAL CONFINED		
IS THE PATIENT CAPABLE OF HOLDING ANY TYPE OF EMPLOYEMENT AT THIS TIME? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, COMMENT:		
PROGNOSIS:		
PHYSICIAN NAME AND ADDRESS	TELEPHONE NUMBER	DATE (M.D.Y.)
PHYSICIAN SIGNATURE	TAX ID NUMBER OR SOCIAL SECURITY NUMBER	

**SEND THIS FORM, WITH ALL THREE SECTIONS COMPLETED, TO THE ADDRESS INDICATED ON THE FIRST PAGE. THIS OFFICE WILL NOTIFY THE EMPLOYEE AND THE EMPLOYER OF THE FINAL DECISION.**