

ConnectiCare, Inc. & Affiliates

Application For Continuation Of Coverage for a Disabled Dependent Child

A.1 Subscriber Information

Subscriber Number: _____ Employer: _____
Last Name: _____ First Name: _____ M.I.: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____

A.2 I hereby apply for ConnectiCare coverage for my disabled child named below:

Last Name: _____ First Name: _____ M.I.: _____
Member # _____ Sex: ___ Male ___ Female Date of Birth: _____

ConnectiCare Primary Care Physician: _____

- Is he/she chiefly dependent on you for support? ___ Yes ___ No
- Is he/she a full-time student? ___ Yes ___ No
- If yes, name of school: _____
- Has he/she ever been gainfully employed? ___ Yes ___ No; If yes, last day actively at work: _____ Name and address of employer: _____
- Does he/she have any other health insurance coverage? ___ Yes ___ No; If yes; name of Insurance Carrier: _____
Name Of Policy Holder: _____
Policy Number: _____
- Is this an Employer Group Health Plan? ___ Yes ___ No; If yes, name of employer: _____

I authorize any physician or other health care provider that has diagnosed or rendered treatment for the above-named dependent to furnish ConnectiCare full information relating to such diagnosis or treatment.

Subscriber's Signature

** Dependent Child's Signature*

** Your dependent child's signature may be required by the evaluating physician/health care provider. To avoid any delay in processing, if your child is capable of doing so, please have him/her sign above.*

Page TWO to be completed by Dependent's physician

This Section To Be Completed By Dependent's Physician

Child's Name: _____ Subscriber ID #: _____

B. Date of last examination: _____

➤ Specific diagnosis of disabling condition: _____

If the disability is due to a mental handicap, attach appropriate documentation (e.g., nature of the handicap, IQ level, date last determined). We will let you know if we need additional information to process this request. To help us with timely and accurate processing, please respond to requests at your earliest convenience.

➤ Extent/Severity of disability: _____

➤ Prognosis of disabling condition: _____

➤ How long has this disability been present? _____

➤ Is the condition expected to be of long continued or indefinite duration? ___ Yes ___ No

1. As the dependent's physician, I certify that the dependent is incapable of self-sustaining employment because of a mental or physical handicap. ___ Yes ___ No

2. I certify that the above statements relative to the dependent named on this form are true to the best of my knowledge and belief.

Evaluating Physician's Signature: _____ Date: _____

Evaluating Physician's printed name and address: _____

Return form to:

**ConnectiCare, Inc.
Group Administration Department
175 Scott Swamp Road
Farmington, CT 06032-3124**

ConnectiCare - Internal Use Only:

New Application _____ **Renewal/Continuation** _____

Additional Information Necessary (Describe): _____

Additional Information Requested By: _____

Date: _____ **Decision:** _____

Reason: _____

Name: _____ **Date:** _____

Additional Comments: _____

