



Health Net of the Northeast, Inc. One Far Mill Crossing P.O. Box 904 Shelton, CT 06484-0944

www.health.net

APPLICATION FOR CONTINUATION OF COVERAGE FOR DISABLED DEPENDENT CHILD BEYOND MAXIMUM AGE

SUBSCRIBER INFORMATION:

Last Name: First Name: Middle Initial:

Health Net ID#: Effective Date:

GROUP INFORMATION:

Group Name: Group:

I HEREBY APPLY FOR HEALTH NET COVERAGE FOR MY DISABLED CHILD NAMED BELOW:

Last Name: First Name: Middle Initial:

Sex: Male Female Date of Birth: Month: Day: Year:

Health Net Primary Care Physician:

I authorize any physician or facility that has diagnosed or rendered treatment for the above named dependent to furnish Health Net full information to such diagnosis or treatment.

Subscriber's Signature:

Subscriber's Address:

THIS SECTION IS TO BE COMPLETED BY A HEALTH NET ATTENDING PHYSICIAN

I certify that the following statement relative to the disabled dependent named on this form are true to the best of my knowledge and belief:

Date of last examination: Diagnosis of disabling condition:

Extent of disability:

Prognosis of disabling condition:

Can the dependent engage in any substantial gainful employment? Yes No

Is this condition expected to be of long continued or indefinite duration? Yes No

Date: Physician's Signature:

Participating Physician's Printed Name and Address:

Please provide the following information in addition to the Continuation of Coverage Application.

**MEMBER INFORMATION**

First Application:  Yes  No

Subscriber's Name: \_\_\_\_\_ Health NetID#: \_\_\_\_\_

Dependent's Name: \_\_\_\_\_ Health Net ID#: \_\_\_\_\_

Diagnosis (Name of Condition): \_\_\_\_\_

Current Age: \_\_\_\_\_ Age at Onset : \_\_\_\_\_ IQ (if applicable): : \_\_\_\_\_

**EDUCATION**

Highest Grade Level at which member took courses: \_\_\_\_\_

Not beyond middle school: \_\_\_\_\_

Senior in High School or beyond: \_\_\_\_\_

**LIVING CIRCUMSTANCES**

Does dependent spend any nights away from home?  Yes  No

Lives at home:  Yes  No

Greater than 25% on own away from home:  Yes  No

Institutionalized:  Yes  No

**EVALUATIONS**

Has dependent had a vocation/education? If so; date of evaluation \_\_\_\_\_

What were the general results?  
\_\_\_\_\_  
\_\_\_\_\_

Too profound, couldn't test  Will send evaluation  Yes, disagree with results

**WORK EXPERIENCE**

Yes  No

In Special Program? \_\_\_\_\_ Various short term positions? \_\_\_\_\_

Is dependent eligible for health insurance at work?  Yes  No

Has any other insurance carrier assigned disabled dependent status to your child?  Yes  No

If yes, Carrier/Date: \_\_\_\_\_

**PLEASE ATTACH DOCTOR NOTES TO THIS FORM**

In the Northeast, coverage is provided by subsidiaries of Health Net of the Northeast, Inc. and Health Net of Pennsylvania, Inc.