

Children with Disabilities Eligibility Form



Instructions to Group Policyholder:

- Request for insurance must be submitted within 31 days* of the first to occur of: 1) becoming eligible for insurance or 2) termination of insurance due to the maximum age limit of dependent children as provided under your plan.
- Upon completion by the employee and yourself, forward this form to the attending physician for the completion of his statement. He, in turn, should send the form to:
Attention: Medical Underwriting, The Hartford, P.O. Box 2999, Hartford, Connecticut 06104-2999
- You will be notified whether the insurance is approved. *120 days if the policy is delivered in the State of Indiana

Name of Group Policyholder (<i>Employer</i>) _____	Policy Number _____
Employee Name _____	Social Security Number _____
Employee Address _____	Home Telephone Number () _____
Employment Date _____	Effective Date of Coverage _____
Total Coverage Amount Requested _____	
Dependent's Effective Date of Coverage, if applicable _____	
Last Date on which the Dependent attended school on a full time basis _____	
This is to certify that _____	
Name of Dependent Child	Birth Date

(1) is my unmarried child, (2) is mentally or physically incapable of earning his own living, (3) became so incapable prior to the limiting age for coverage of children under this policy and (4) is primarily dependent upon me for support and maintenance.

The nature of the disability is _____
; and it commenced _____

With respect to the above named child, I hereby request insurance which would: 1) otherwise not be available due to exceeding the limiting age for dependent children or 2) otherwise terminate due to attainment of the limiting age under the group policy.

I understand that on the part of the Insurance Company no liability for claim exists with respect to any period of time prior to the receipt and approval of this form by The Hartford, or its representatives.

The Hartford is authorized to contact my child's attending physician to obtain necessary information concerning my child's incapacity.

Signature of Group Policyholder (<i>Employer</i>) _____	Signature of Employee _____
	Date _____

Attending Physician's Statement *(to be completed at employee's expense)*

Diagnosis, Concurrent Condition, and Prognosis:

Physician _____	Signature _____	Degree _____	() Telephone _____
Name (<i>Please print.</i>)			
Full Address _____ (Street, City or Town, State & Zip Code)			

For Home Office Use Only	<input type="checkbox"/> Approved for Coverage By: _____	Claim Dept. Follow-up Recommendation
	<input type="checkbox"/> Declined for Coverage Date: _____	<input type="checkbox"/> Frequent (<i>Condition expected to change</i>)
		<input type="checkbox"/> Infrequent