Request for Continuation of Coverage for a Disabled Dependent

Primary Insured's Name:	Primary Insured's Identification Number:
Dependent Name	Dependent date of birth
Relationship to Employee:	Dependents Social Security Number:
Dependents Gender:	Dependents Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Does this dependent reside with you? Yes ☐ No ☐

Do you provide 100% or more of the dependents support? Yes ☐ No ☐

Is this dependent a current SSI recipient due to disability? Yes* ☐ No ☐

** Please enclose letter of determination from Social Security.*

Does this dependent have Medicare A or Part B? Yes ☐ No ☐

If yes:
What is the effective date? _____

Has he/she ever been gainfully employeed? Yes ☐ No ☐

If yes: Last day actively at work: _____

Does he/she have any other health insurance coverage? Yes ☐ No ☐

If yes:
Name of Insurance Carrier: _____

Name of Policy Holder: _____

Policy Number: _____

Effective Date: _____

Is this an Employer Group Health Plan? Yes ☐ No ☐

If yes:
Name of the Employer: _____

Signature of the Primary Insured: _____ Date: _____

This portion to be completed by the attending Physician

This portion outlines documentation to be submitted by the dependent's personal physician. Information must be current (i.e. the patient has been examined within the last 6 months for medical or 3 months for mental health).

Diagnosis _____ Date of onset of condition: _____

Prognosis _____ Is this a temporary or permanent disability _____

If temporary, date of anticipated recovery _____

Does this condition impose on the individual's ability to perform daily duties, maintain gainful employment or maintain student status? Yes ☐ No ☐

Is the dependent in an institution? Yes ☐ No ☐

Name of the Physician: _____

Physician's Address: _____

_____

Signature of Physician: _____

*For **medical disability request** , please attach the most recent history and physical, which document the diagnosis and functional limitations.*

*For **mental health disability** , please attach the most recent psychiatric evaluation which documents the diagnosis and the functional limitations.*

All Protected Health Information provided by your dependent's physician will be kept confidential in accordance with the HIPAA laws and will only be reviewed for the purpose of determining your dependents disability and eligibility for insurance.

Once this form and medical notes are returned along with the signed authorization form, we will review for a determination. Please allow 30 days.