Application For Continuation Of Coverage for a Disabled Dependent Child

A.1 Subscriber Information

SubscriberNumber:_____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.*

<u>Page TWO to be completed by Dependent's physician</u>

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. & Affiliates
Group Administration Department
P.O. Box 4058
Farmington, CT 06034-4050

_____

ConnectiCare - Internal Use Only:
New Application _____ Renewal/Continuation _____
Additional Information Necessary (Describe): _____

_____

Additional Information Requested By: _____
Date: _____ **Decision:** _____
Reason: _____
Name: _____ **Date:** _____
Additional Comments: _____

_____

_____

_____

Do Not Separate Pages