

INCAPACITATED DEPENDENT CERTIFICATION FORM

SECTION 1: To be completed by the EMPLOYEE

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|---|--|
| Employee Name: | |
| Employee ID Number: | |
| Dependent's Name: | |
| Please answer all questions below regarding the Dependent referenced above. | |
| Does the dependent resides with you? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Receiving their principal financial support from you? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Receiving Social Security Income? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Claimed by you as a dependent for Federal Income purposes? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Eligible for any other privately or publicly funded health benefit? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Other Coverage Information | |
| Is the dependent referenced above covered by any other coverage including Medicare? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| *If yes, please provide us with the other coverage's name: | |
| Policy Number: | |
| Effective Date: | |
| Employment Information | |
| Is the dependent referenced above employed? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| If yes, Employer's Name: | |
| Hours worked per week: | |
| Dates of Employment: | |
| Duties performed: | |
| If no, please indicate what is preventing the dependent from being employed? | |
| Dependent Student Information | |
| Is the dependent referenced above a student? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| If yes, please indicate name of school: | |
| Number of semester hours enrolled: | |
| Is this a custodial care facility? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Highest education level reached: | |
| <p>I represent that to the best of my knowledge and beliefs the statement and answers made by me on this form are complete and correct. I understand that continuation of coverage for a handicapped dependent is subject to approval and is based on the applicable health benefits plan and on the documentation submitted to Community Care Plan in support of this request for continuation of coverage.</p> | |
| Employee Signature: | |
| Date: | |

SECTION 2: Employee Release and Signature

I authorize completion of this form by my dependent's physician and the release of my dependent's medical records to Community Care Plan.

Employee Signature: _____

Date: _____

SECTION 3: to be completed by the dependent's PRIMARY CARE / ATTENDING PHYSICIAN

Please complete the questions below for the aforementioned dependent and attach medical documentation supporting this information. The subscriber's signature above serves as authorization for your office to release any additional information requested concerning this dependent. Coverage may be extended beyond the usual dependent age limit for an unmarried Enrolled Dependent if he/she is incapable of self-support due to a mental and /or physical handicap and if he/she depends mainly upon the subscriber for support.

What is the Diagnosis? _____

Date you first attended dependent: _____

Date you last saw dependent: _____

What is the nature of the incapacity? _____

How long has the mental/physical incapacity existed? _____

Do you believe the incapacity will last greater than one year? _____

Is the dependent receiving treatment for the underlying condition? (If yes, what is the treatment?): _____

Prognosis for recovery from the incapacitating condition: _____

In your opinion, is the dependent capable of self-support? YES NO

*If no, what prevents such support: _____

Can this dependent perform any type of work? YES NO

*If yes, explain: _____

PHYSICIAN'S STATEMENT: It is my opinion that the above named dependent is incapable of self-support due to the handicap(s) described and must depend mainly on the subscriber for support.

Physician's Signature: _____

Physician's Name (Print): _____

Date: _____

Address: _____

Phone: _____

Fax: _____

For Internal use only:

Approve

Temporary Approval

Deny

Coverage Determination Date: _____ Signature: _____