Request for Continuation of Coverage for Incapacitated Children

Request for continuation of insurance should be completed and sent by you to the CBA Blue Eligibility Department.

Subscriber Name (Please print) _____ Subscriber Number _____

This is to certify that _____ Dependent's Name _____ Date of Birth

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

What is nature of incapacity and when did it begin?

_____

_____

_____

I request continuance of insurance, which would otherwise terminate on attainment of the age limitation of the group policy.

CBA Blue is authorized to contact my child's attending physician (name and address indicated below) and obtain information concerning my child's incapacity.

_____
Physician's name and address

I recognize that any cost associated with the release of this medical information will be at my expense. Fraudulent information is cause for immediate or retroactive termination of coverage.

_____ Subscriber Signature _____ Date

Physician's Statement of Mental or Physical Handicap

Subscriber Name (Please Print) _____ Employer _____

Dependent _____ Relationship _____ Subscriber Number _____

1. Nature and degree of mental or physical handicap. (Please furnish full diagnosis.)

2. How and when above condition commenced.

3. Date individual was last examined.

4. How handicap restricts the individual's ability to engage in normal activities.

5. EXTENT OF DISABILITY:

	Disabled for any occupation?	Disabled for regular occupation?
(a) Is patient now totally disabled?	Yes ____ No ____	Yes _____ No _____
(b) If no, when was patient able to go to work?	___/___/_____	___/___/_____.
(c) If yes, when do you think patient will be able to go to work?	Aprox. Date _____ Indefinite _____ Never _____	Approx. Date _____. Indefinite _____. Never _____.
(d) If yes, is patient a suitable candidate for a rehabilitation program?	Yes _____ No ____	Yes ____ No ____.

6. Please furnish any other information, which you think would help us make a fair disability determination.

_____

_____

Signed: _____ MD Address: _____

Date: _____ _____