

# APPLICATION FOR CONTINUATION OF COVERAGE:

For a child who is incapable of self-sustaining employment by reason of mental or physical disability and who has reached the limiting age for dependent children specified in the plan or contract

or

For continuation of dependent coverage for college students (FTS) who would otherwise lose eligibility because of a reduction in their full-time class status or a medically necessary leave of absence from school itself.

Please type or print

<b>SECTION 1 – TO BE COMPLETED BY EMPLOYEE</b>			
Dependent Child's Name (Last, First, Initial)	Child's Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Child's Birth Date Mo. Day Yr.	Relationship to Employee
Employee's Name (Last, First, Initial)	Identification #	Group #	Name of Employer
Employee's Address (Number, Street, City, State, Zip code)		Employee Telephone Number	
Child's Marital Status Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/>	Date Child's Disability Occurred	Is Child Permanently Residing in Your Household? Yes <input type="checkbox"/> No <input type="checkbox"/> If "No," explain.	
Is Child Dependent on You For support? Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes," What Part of Support Do You Contribute? (% of Total)	Was Child Taken as a Dependent on Your Last Income Tax Return? Yes <input type="checkbox"/> No <input type="checkbox"/>	Was dependent a full time college student prior to medical event? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is Child Employed Now? Yes <input type="checkbox"/> No <input type="checkbox"/>	Was Child Ever Employed? Yes <input type="checkbox"/> No <input type="checkbox"/>	If Answer to either of the Last Two Questions is "Yes," Give Name(s), Address(es) of Employer(s) and Date(s) Employed	
Is Dependent Covered Under Any Other Health Plan? Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes," Give Name and Address of Insurance Company		
<p>I have read the foregoing statement and answers and declare them to be true and complete to the best of my knowledge. I hereby authorize any physician or other person who has attended my above-named dependent child or who may hereafter attend or examine such child to disclose any knowledge or information thereby acquired by him/her to AultCare and The Plan Administrator.</p>			
Date		Signature of Employee	
Soc. Sec. No. of Employee			
Signature of Dependent or authorized individual			
Relationship to Dependent			

**APPLICATION FOR CONTINUATION OF COVERAGE--continued**

<b>SECTION II – TO BE COMPLETED BY ATTENDING PHYSICIAN</b>			
Dependent Child's Name (Last, First, Initial)	Child's Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Child's Birth date Mo. Day Yr.	Relationship to Employee
Employee's Name (Last, First, Initial)	Identification #	Group #	Name of Employer
Employee's Address (Number, Street, City, State, Zip code)	Employee Telephone Number		
Has Child's Disability Existed Continuously Up to the Present? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date Child's Disability Occurred:	Prognosis (Est. months or years)	Is Child now Incapable of Self-Support Because of the Disability? Yes <input type="checkbox"/> No <input type="checkbox"/>

**Nature of Disability (Please give as much detail as practicable) – Use other side of sheet if necessary.**

**What functional ability does this patient lack?**

Mental: \_\_\_\_\_

Physical: \_\_\_\_\_

**Why is this patient unable to work or maintain a full time class status?** \_\_\_\_\_

**COMPLETE DIAGNOSIS:** \_\_\_\_\_

**How long has this member been under your care?** \_\_\_\_\_

**Date of last medical examination:** \_\_\_\_\_

**Documented findings from last medical examination:**

\_\_\_\_\_

Printed Name of Physician	Date
Signature of Physician	
Physician's Address	Physician Telephone Number
Physician Degree/Specialty	DEA#

**To Physician: Please return form directly to AultCare Service Center  
P.O. Box 6910  
Canton, OH 44706**