



REQUEST FOR CONTINUATION OF HEALTH COVERAGE FOR INCAPACITATED DEPENDENT CHILD

Employee/plan enrollee instructions:

- Complete sections 1 through 6 on this form.
- Print the information requested, except for the signature section.
- Obtain your incapacitated dependent child's Attending Physician's Statement.
- Forward this completed form to:

Office of Group Benefits Eligibility Division Post Office Box 44036 Baton Rouge, LA 70804 FAX: 225-342-9917

Note: OGB has the right to:

- Require proof of the continuation of the dependent child's incapacity.
- Examine or require examination of your dependent child (at his/her/your own expense) as often as OGB may deem necessary while the continued coverage is effective.

Continuation of coverage will automatically terminate the last day of the month in which any one of the following events first occurs:

- Cessation of your dependent child's incapacity.
- Failure to provide timely proof of your dependent child's continuing incapacity.
- Failure to have any OGB required exam.
- Termination of your dependent child's coverage for reasons other than reaching the maximum age.

1.Plan	Name	Social Security Number		
Enrollee				
Informatio	Address (street, city, state, zip code)			
n				
2.Plan Enrollee Certificatio n	I hereby certify that, to the best of my knowledge and beliefs, the statement and answers made on this form are complete and correct. I understand that continuation of coverage for an incapacitated dependent child is subject to approval by the Office of Group Benefits based on the applicable health plan and the documentation submitted to OGB in support of this request for continued coverage.			
	Plan Participant's Signature	Date		
3. Plan	NOTICE			
Enrollee				
Notice	If you enroll someone that is not eligible for coverag intentional misrepresentation of material fact. The issu on the representations and statements contained in th are material to the issuance of this coverage. Any in	uance of continued coverage is conditioned is required form. All representations made		





	child, shall constitute an inter	nally omitted therefrom, as to any propositional misrepresentation of material fact. vely to the effective date of coverage fact.	A plan enrollee's coverage		
4. Dependent Child	Name	Birth Date (MM/DD/YY)	Social Security Number		
Informatio n	When did the incapacity start?				
	Mental Incapacity: (Date) Physical Incapacity: (Date)				
	School History:				
	Have you been attending school or a training facility since reaching age 26? 🗖 yes 🛛 no				
	Work History:				
	Have you been working? 🗖 yes 🗖 no				
	If yes, complete the following:				
	Employer Name Employment Dates Hours worked Hourly Wage Description of				
	1	Weekly D	uties		
	2.		-		
	3				
	4				
	(For additional work experience or information, attach an 8½ X 11 paper. Use same format as				
	work experience on this application.)				
	Living Arrangement: Do you live with the plan enrollee? yes no If no, where do you live?				
	<u>Financial Support</u> : Does the plan enrollee claim you as a dependent for federal income tax purposes? U yes U no				
	Does the plan enrollee provide more than one-half of your financial support? yes no If no, please explain:				
			-		
5. Dependent Child	I acknowledge, agree, and declare that the foregoing information is true and correct.				
Signature	Signature and date of dependent child or representative:				
			Date		
	Printed name of signing party	(dependent child or representative):			





	Signing party's relationship to dependent child:		
6. Attending Physician	Name		
Informatio n	Address (street, city, state, zip code)		
	Telephone Number, including the area code: ()		
7. Attending Physician's	This part is required to be completed by your doctor. Please complete and sign the attached Medical Release Authorization and submit it to your doctor with this form:		
Statement	The following questions may be answered on this form or on a separate sheet of paper. This form is required to be submitted with your reply.		
	1. Exact diagnosis and any related condition, symptoms, disease or disease processes:		
	2. Date first diagnosed: (MM/DD/YYYY)		
	3. Treatment rendered, including dates and any medications:		
	4. Restriction of activities as a result of condition:		
	5. Current condition:		
	6. Prognosis for recovery:		
	7. Attach a copy of pathology report, if applicable.		





8. Include any paperwork demonstrating permanent disability.
Physician Attestation:
I, to the best of my knowledge, attest that the dependent child is incapable of self-sustaining employment.
9. Doctor's signature and date:
10. Printed or stamp name of Doctor: