STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS
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, which should contain your official signature.
- Obtain your 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

****Members enrolled in an LSU First Health Plan MUST submit request to the LSU First Health Plan, not OGB.***

Note: OGB has the right to:

- Require proof of the continuation of the dependent child's incapacity.
- Require an annual examination of your dependent child (at his/her/your own expense) 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 timely provide proof of your dependent child's continuing incapacity;
- Failure to timely complete any OGB required exam; or
- Termination of your dependent child's coverage for reasons other than reaching the maximum age.

PLAN ENROLLEE INFORMATION (Please print or type)			
NAME (LAST, FIRST, MIDDLE INITIAL)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	
ADDRESS	CITY	STATE	ZIP CODE

PLAN ENROLLEE NOTICE

NOTICE

Continued coverage beyond age 26 for an incapacitated dependent child is conditioned upon the validity and accuracy of the information and representations contained in this required form. All information requested is material to the issuance of coverage. Providing false information or purposefully omitting material information from this request shall be considered an act of fraud or intentional misrepresentation of material fact. A plan enrollee's coverage may be rescinded retroactively to the effective date of coverage for any such misrepresentation.

PLAN ENROLLEE CERTIFICATION

I HEREBY CERTIFY, to the best of my knowledge, information and belief, that the information and responses included in this request are complete, true and correct.

I FURTHER CERTIFY my understanding that continuation of coverage for the incapacitated dependent child is subject to approval by the Office of Group Benefits based upon the terms and provisions of the applicable health plan and the information and documentation submitted to OGB in support of this request for continued coverage.

Plan Enrollee's Signature _____ Date _____

OGB - REQUEST FOR CONTINUATION OF HEALTH COVERAGE FOR INCAPACITATED DEPENDENT CHILD (CONTINUED)

DEPENDENT CHILD INFORMATION (Please print or type)

NAME (LAST, FIRST, MIDDLE INITIAL)	SOCIAL SECURITY NUMBER	DATE OF BIRTH

WHEN DID THE INCAPACITY START?

☐ Mental Incapacity: (Date) _____ ☐ Physical Incapacity: (Date) _____

SCHOOL HISTORY:

Have you been attending school or a structured training program prior to reaching age 26? ☐ Yes ☐ No

Name of school or structured training program: _____

Dates attended: _____

(For additional school or training program information, attach an 8½ X 11 paper. Use same format as school history on this application.)

WORK HISTORY:

Have you been working? ☐ Yes ☐ No

If yes, complete the following:

Position1:

Employer Name: _____

Employment Dates: _____

Weekly Hours Worked: _____

Description of Duties: _____

Position2:

Employer Name: _____

Employment Dates: _____

Weekly Hours Worked: _____

Description of Duties: _____

(For additional work experience or information, attach an 8½ X 11 paper. Use same format as work experience on this application.)

OGB - REQUEST FOR CONTINUATION OF HEALTH COVERAGE FOR INCAPACITATED DEPENDENT CHILD (CONTINUED)

LIVING ARRANGEMENT:

Do you live with the plan enrollee? ☐ Yes ☐ No

If no, what is your current living arrangement? _____

Current Address(If not living with Plan Enrollee)

ADDRESS	CITY	STATE	ZIP CODE

PHONE NUMBER (INCLUDING AREA CODE)	E-MAIL ADDRESS (if applicable)

FINANCIAL SUPPORT:

Does the plan enrollee claim you as a dependent for federal income tax purposes? ☐ Yes ☐ No

Does the plan enrollee provide more than one-half of your financial support? ☐ Yes ☐ No

If no, please explain and provide proof of financial support relied upon:

_____

_____

_____

_____

LIFE INSURANCE CONTINUATION:

If the plan enrollee currently has a life insurance policy through OGB, does he or she wish to continue coverage on his or her dependent? ☐ Yes ☐ No

DEPENDENT CHILD / REPRESENTATIVE SIGNATURE

I acknowledge, agree, and declare that the foregoing information is true and correct.

Dependent Child: _____ Date: _____
Dependent Child's Signature

or

Representative: _____ Date: _____
Representative's Signature

Printed name of signing party (dependent child or representative):

Dependent Child: _____

Representative: _____

Representative's relationship to dependent child: _____

OGB - REQUEST FOR CONTINUATION OF HEALTH COVERAGE FOR INCAPACITATED DEPENDENT CHILD (CONTINUED)

ATTENDING PHYSICIAN INFORMATION (Please print or type)

PHYSICIAN NAME	SPECIALIZATION		
ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER (INCLUDING AREA CODE)	FAX NUMBER (INCLUDING AREA CODE)		

ATTENDING PHYSICIAN'S STATEMENT

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:

The following questions may be answered on this form or on a separate sheet of paper. You are required to submit this form 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. Limitations and/or restrictions of activities as a result of condition:

5. Prognosis for recovery:

6. Attach any paperwork supporting permanent disability.

PHYSICIAN ATTESTATION

I, _____ to the best of my knowledge, attest that the dependent
(Printed First and Last Name of Physician)

child _____ is incapable of self-sustaining employment.
(Printed First and Last Name of Child)

_____ _____
Physician's Signature Date