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

SECTION 1 – TO BE COMPLETED BY EMPLOYEE

Dependent Child's Name (Last, First, Initial)	Child's Sex Male ☐ Female ☐	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 ☐ Widowed ☐ Married ☐ Divorced ☐	Date Child's Disability Occurred	Is Child Permanently Residing in Your Household? Yes ☐ No ☐ If "No," explain.

Is Child Dependent on You For support? Yes ☐ No ☐	If "Yes," What Part of Support Do You Contribute? (% of Total)	Was Child Taken as a Dependent on Your Last Income Tax Return? Yes ☐ No ☐	Was dependent a full time college student prior to medical event? Yes ☐ No ☐

Is Child Employed Now? Yes ☐ No ☐	Was Child Ever Employed? Yes ☐ No ☐	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 ☐ No ☐	If "Yes," Give Name and Address of Insurance Company

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.

_____

Date — Signature of Employee

_____

Soc. Sec. No. of Employee

_____

Signature of Dependent or authorized individual

_____

Relationship to Dependent

APPLICATION FOR CONTINUATION OF COVERAGE--continued

SECTION II – TO BE COMPLETED BY ATTENDING PHYSICIAN			
Dependent Child's Name (Last, First, Initial)	Child's Sex Male ☐ Female ☐	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 ☐ No ☐	Date Child's Disability Occurred:	Prognosis (Est. months or years)	Is Child now Incapable of Self-Support Because of the Disability? Yes ☐ No ☐

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