



## REQUEST FOR CONTINUATION OF HEALTH COVERAGE FOR INCAPACITATED DEPENDENT CHILD

### Employee / Plan Enrollee Instructions:

- Complete sections 1-6 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:

WebTPA, Inc  
Attn: Eligibility  
PO Box 1808  
Grapevine, TX 76099-1808

### Note - LSU First 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 LSU First 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 A plan enrollee's coverage may be rescinded retroactively to the effective date of coverage for any such misrepresentation.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 LSU First based upon the terms and provisions of the applicable health plan and the information and documentation submitted to LSU First in support of this request for continued coverage.

Plan Enrollee's Signature

Date



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.)



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**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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DEPENDENT CHILD / REPRESENTATIVE SIGNATURE**

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

Dependent Child: \_\_\_\_\_ Date: \_\_\_\_\_  
or Dependent Child's Signature

Representative: \_\_\_\_\_ Date: \_\_\_\_\_  
Representative's Signature

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

Dependent Child: \_\_\_\_\_

Representative: \_\_\_\_\_

Representative's relationship to dependent child: \_\_\_\_\_



REQUEST FOR CONTINUATION OF HEALTH COVERAGE FOR  
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**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.



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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 \_\_\_\_\_