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:

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 A plan enrollee's coverage may be rescinded retroactively to the effective date of coverage for any such misrepresentation.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.
1. The dependent became disabled before reaching the limiting age; and
2. Is incapable of self-sustaining employment du e to disability; and
3. The dependent relies primarily upon Subscriber (and/or spouse) for support and maintenance.

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 _____

LSU FIRST

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
Marital Status? ☐Yes ☐No		
Does the dependent have any Other / Additional Health Insurance? ☐ Yes ☐ No *If Yes, provide responses in the fields below.*		
Other/Additional Health Insurance Name:	Other Health Insurance ID Number:	Customer Service Number:
Is the Other Health Insurance company Primary coverage for the dependent? ☐ Yes ☐No		
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: To: _____ From: _____

(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:

Position 1:

Employer Name: _____ Employment Dates: _____

Weekly Hours Worked: _____ Description of Duties: _____

Position 2:

Employer Name: _____ Employment Dates: _____

Weekly Hours Worked: _____ Description of Duties: _____

(For additional work experience or information, attach an 8½ X 11 paper. Use same form as work history section)

SOCIAL SECURITY DISABILITY OR LEGAL GUARDIANSHIP SUPPORTING DOCUMENTS

Has the dependent been declared disabled by the Social Security Administration?

☐ If **Yes**, (attach SSDI *and SSI** document)
☐ If **No**, provide subscriber signature below and then continue to section 3

If **yes**, complete the following:

- Copy of the SSDI* Award letter
- Most recent monthly SSI** statement
  and/or
- Applicable court order
- Sign on the Subscriber signature line and **STOP**

If **no**, provide subscriber signature and then continue to section 3.

Subscriber Signature:

_____

OR

Has the dependent been placed in Legal Guardianship by a court order?

☐ If **Yes**, (attach active court order)
☐ If **No**, provide subscriber signature below and then continue to section 3

If **yes**, complete the following:

- Attach the copy of the active Legal Guardianship court order
- Sign on the Subscriber signature line and **STOP**

If **no**, provide subscriber signature below and then continue to section 3.

Subscriber Signature:

_____

LSU FIRST

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:

_____

_____

_____

_____

_____

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 Signature

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

Dependent Child: _____

Representative: _____

Representative's relationship to dependent child: _____

LSU FIRST

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

ATTENDING PHYSICIAN INFORMATION (Please print or type)		
PROVIDERS NAME	PROVIDERS MAILING ADDRESS	PROVIDER CONTACT: _____ PHONE: _____ FAX NUMBER: _____
DATE OF PATIENT'S LAST EXAM: (The application date and date of the last exam must be Must be within the past year) _____	DISABILITY IS COMPLETE 100% ☐ Yes ☐ No	Disability is: Partial _____%
Is this disability temporary or permanent? ☐ Temporary ☐ Permanent		If temporary, estimated duration: _____
Diagnosis causing disability: (provide ICD-10 and standard nomenclature of condition)		
Limitations and/or restrictions of activities because of condition(s):		
Will dependent/patient be capable of self-support ☐ Yes ☐ No If yes, when (date) _____		
Signature of Attending Physician (Print / Credentials): _____ Date of Signature: _____ *(My signature attests that the above statements are true and if requested I can provide further substantiating documentation.)*		