Application for Continuation of Coverage for a Disabled Dependent Child

ConnectiCare

Subscriber Information			
Subscriber number:	Employer:		
Last name:	First name:	M.I.:	
Street address:			
City:	State:	ZIP code:	

I hereby apply for ConnectiCare coverage for my disabled child named below:		
Last name:	First name:	M.I.:
Member number:	Sex: ☐ Male ☐ Female	Date of birth:

Are they chiefly dependent on you for support? ☐ Yes ☐ No

Are they a full-time student? ☐ Yes ☐ No

If yes, name of school: _____

Have they ever been gainfully employed? ☐ Yes ☐ No If yes, last day actively at work: _____

Name and address of employer: _____

Do they have any other health insurance coverage? ☐ Yes ☐ No

If yes; name of insurance carrier: _____

Name of policy holder: _____

Policy number: _____

Is this an employer group health plan? ☐ Yes ☐ No

If yes, name of employer: _____

I authorize any doctor or other health care professional who has diagnosed or rendered treatment for the above-named dependent to furnish ConnectiCare full information relating to such diagnosis or treatment.

Subscriber's signature

Dependent child's signature*

*Your dependent child's signature may be required by the evaluating doctor/health care professional. To avoid any delay in processing, if your child is capable, please have them sign above.

PAGE TWO TO BE COMPLETED BY DEPENDENT'S DOCTOR.

DO NOT SEPARATE PAGES.

PRINT RESET

THIS SECTION TO BE COMPLETED BY DEPENDENT'S DOCTOR

Primary Care Provider (PCP):	
Child's name:	Subscriber ID number:
Date of last examination:	Specific diagnosis of disabling condition:
If the disability is due to a mental handicap, attach appropriate documentation (e.g., nature of the handicap, IQ level, date last determined). We will let you know if we need additional information to process this request. To help us with timely and accurate processing, please respond to requests at your earliest convenience.	
Extent/severity of disability:	Prognosis of disabling condition: / How long has this disability been present?
Is the condition expected to be of a continued or indefinite duration? ☐ Yes ☐ No As the dependent's doctor, I certify that they are incapable of self-sustaining employment because of a mental or physical handicap. ☐ Yes ☐ No	
I certify that the above statements relative to the dependent named on this form are true to the best of my knowledge and belief.	
Evaluating doctor's Signature:	Date:
Evaluating doctor's printed name and address:	

Return form to:

ConnectiCare, Inc. & Affiliates
Group Administration Department
P.O. Box 4058
Farmington, CT 06034-4050

ConnectiCare — Internal Use Only:		
New application:	Renewal/continuation:	
Additional information necessary (describe):		
Additional information requested by:		
Date:	Decision:	
Reason:		
Disability term: ☐ two years ☐ four years ☐ Other:		
Name:	Date:	
Additional comments:		