REQUEST FOR CONTINUATION OF COVERAGE FOR DISABLED DEPENDENT CHILD

IF AN EMPLOYEE OR MEMBER HAS A DISABLED CHILD WHO, UNDER THE TERMS OF THE PLAN, QUALIFIES FOR COVERAGE AFTER THE POLICY LIMITING AGE, THIS FORM MUST BE COMPLETED AND SUBMITTED TO INNOVATED HEALTH PLAN WITHIN 31 DAYS FOLLOWING THE ATTAINMENT OF THE LIMITING AGE.

SECTION 1
(TO BE COMPLETED BY THE EMPLOYEE)

Name of Employee (print last, first, middle initial) ______________________________

Address (number, street, city, state and zip code) ______________________________

1) Employee Member ID Number______________________________

2) Full Name of Child______________________________ Relationship (to employee) ______________________________

3) Child's Date of Birth ______________________________

4) Are you a new employee? Yes ☐ No ☐

If yes, was child previously covered as a disabled dependent under former employer? Yes ☐ No ☐

Effective date of coverage: ______________________________ Termination date of coverage: ______________________________

5) Did such disability exist prior to child's attainment of limiting age under the group plan? Yes ☐ No ☐

6) Child's Marital Status: Single ☐ Widowed ☐ Married ☐ Divorced ☐

7) Is child dependent upon you for support? Yes ☐ No ☐

If yes, what part of support do you contribute? ______________________________

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8) Was child ever employed? Yes ☐ No ☐

9) Is child employed now? Yes ☐ No ☐ If so, Full or Part time?______________________________

10) If yes to either question 8 or 9, give name(s) and address(es) of employer(s) and dates employed: ______________________________

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11) <u>Summary of Any Institutional Care:</u>

Names of Institutions: ______________________________

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Dates: ______________________________

Nature of Care: ______________________________

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I hereby declare that all statements and answers to the above questions are complete and true.

Signature of Employee ______________________________ Date ______________________________

INNOVATIVE HEALTH
PLAN II
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SECTION 2
(TO BE COMPLETED BY THE PHYSICIAN)

Is child now incapable of self-sustaining employment because of Mental or Physical Disability? Yes☐ No☐

May child be employable in future? Yes☐ No☐ Questionable☐

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Date of Onset: ____

Prognosis: ____

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Please list restrictions on work capacity and provide real life examples of what the patient can and cannot do: ____________________

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____

Name of Physician (type or print) Physician's Signature Degree

____

Address (number, street, city, state, and zip code)

____

Mail, e-mail or fax this completed form to: Innovative Health Plan
6 North Park Drive, Suite 310
Hunt Valley, MD 21030-4377
Fax 410-584-9467
Claims@gbsio.net