Application For Extension of Group Insurance on Physically or Mentally Disabled Dependent

The Plan will provide coverage for all eligible disabled Dependents who have been continuously covered, with no break of more than 63 days, under any accident and health insurance since the age of 26. EMI Health may require subsequent proof of disability and dependency after the child reaches age 26, but not more often than annually.

SECTION 1 - STATEMENT OF DEPENDENT'S ELIGIBILITY (to be completed by the Employee)

Employee's Name

Member ID Number

Employee's Address | City | State | ZIP Code

Dependent's Name

Dependent's Birthdate

Dependent's Relationship to Employee

Dependent's Marital Status ☐ Single ☐ Married

Dependent's Address (if not residing with employee) | City | State | ZIP Code

Please explain why dependent does not reside with employee

Is dependent currently employed? ☐ Yes ☐ No

Dates Employment Began ______

Position Held: ______

Average Hours Worked Per Week ______

Dependent's Current Employer's Name

Dependent's Current Employer's Address | City | State | ZIP Code

Was dependent previously employed? ☐ Yes ☐ No

Dates of Employment ______ to ______

Position Held: ______

Average Hours Worked Per Week ______

Dependent's Previous Employer's Name

Dependent's Previous Employer's Address | City | State | ZIP Code

Does dependent have other health insurance coverage? ☐ Yes ☐ No

If yes, please provide the name of the carrier, employee name, policy number, and carrier's phone number:

Is the dependent eligible for or have Medicare coverage? ☐ Yes ☐ No

If yes, please provide the type of coverage, effective date, and the Medicare MBI number:

Has the dependent been declard disabled by the Social Security Administration? ☐ Yes ☐ No

If yes, what is the date of acceptance? (please attach a copy of the SSI acceptance letter) ______

I certify that ______ meets the following criteria:

Name of incapacitated dependent

1) Has been continuously covered by health insurance as my dependent with no break in coverage of more that 63 days;
2) Is incapable of self-sustaining employment due to incapacitation related to developmental disability, medical disability, and/or mental disorder; and
3) For a child over age 26, is significantly dependent upon employee (and/or employee's spouse) for support and maintenance.

______

Signature of Employee

______

Date

SECTION 2 - STATEMENT OF INCAPACITATION (to be completed by the dependent's attending physician*)

Provider's Name				Provider's Telephone Number
Provider's Address	**City**	**State**	**ZIP Code**	**Provider's Tax ID Number**
Patient's Name				**Patient's Birthdate**

Date patient was last examined by attending physician

Nature of condition causing incapacity:
☐ Development Diability ☐ Medical Disability
☐ Mental Discorder ☐ Other (please explain) ____________________

Incapacitation is:
☐ Complete
☐ Partial ____________ % incapacitated

Dependent's Incapacitation Status
☐ Temporary (estimated duration is) ____________________ ☐ Permanent
At what age did patient become incapacitated? ____________________

Diagnosis of Condition Causing Incapacity: *(Give as much detail as possible. Please give dates of surgery, forward laboratory data, and results of special tests, such as x-rays, EKG's, EEG's, etc. Attach additional pages as necessary)*

Diagnosis ____

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Comments to Support Incapacity ____

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Is patient or will patient be capable of self-support? ☐ Yes ☐ No

If yes, from ____

Is patient able to perform full or part-time work of any kind? ☐ Yes ☐ No

Has patient previously been able to perform full or part-time work of any kind? ☐ Yes ☐ No

____________________	____________________
Attending Physician's Name	Attending Physician's Credentials
▶ ____________________	____________________
Signature of Attending Physician	**Date**

*The attending physician's statements regarding incapacitation are necessary and important for EMI Health's incapacitation determination; howver, EMI Health is not bound by the physician's conclusion.

When form is completed, please return to enrollment@emihealth.com