

po box 1407, church street station new york, ny 10008-1407

Identification Number	

## Dear Member:

We are glad to confirm that our family contracts can cover mentally challenged or physically handicapped overage dependents, provided the child:

- became mentally challenged, developmentally disabled, mentally ill or physically handicapped before reaching the contract age limit for dependent children
- •has not married
- •is so incapacitated as to be incapable of self-sustaining employment (NOTE: The inability to find employment or a reduction in work capability does not constitute evidence of eligibility.)

When a mentally challenged or physically handicapped child over the contract age is eligible as a dependent under a family membership, all the benefits of that membership apply. Of course, our contracts do not provide benefits which are available in whole or in part under the laws of the United States of America or any state or political subdivision thereof.

Please have the form on the reverse side of this letter fully completed and returned to us so we may take the necessary action.

Sincerely, Membership & Billing

PLEASE READ THIS LETTER PRIOR TO FILLING OUT THE FORM ON THE REVERSE SIDE OF THIS PAGE.

## REQUEST FOR OVERAGE DEPENDENT COVERAGE

FOR UNMARRIED DEPENDENT CHILD <u>OVER</u> THE DEPENDENT AGE LIMIT IN THE CONTRACT WHO IS MENTALLY CHALLENGED, DEVELOPMENTALLY DISABLED, MENTALLY ILL OR PHYSICALLY HANDICAPPED PRIOR TO HIS OR HER INELIGIBLE DATE OF COVERAGE WITH EMPIRE <u>INSTRUCTIONS</u>:

<u>CONTRACT HOLDER</u> — Please complete Section I of this form.

ATTENDING PHYSICIAN — Please complete Section II of this form.

NOTE: THIS REQUEST FORM WILL NOT BE ACCEPTED UNLESS ALL SECTIONS ARE COMPLETED

SECTION I — TO BE COMPLETED BY CONTRACT HOLDER								
NAME OF CONTRACT HOLDER ADDRESS OF CONTRACT HOLDER (NO. & STREET, CITY, STATE, ZIP CODE, APT. NO.)								
NAME OF DEPENDENT CHILD  ADDRESS OF DEPENDENT CHILD (NO. & STREET, CITY, STA	SEX ID NUMBER OF DEPENDENT CHILD    M		DEPENDENT'S D.O.B.  MONTH DAY YEAR  MEMBER ID NUMBER		DEPENDENT'S MARITAL STATUS  SINGLE WIDOWED  MARRIED DIVORCED  GROUP NUMBER			
	, 2 001	52,7,				and nomber		
MAS DEPENDENT CHILD EVER INSTITUTIONALIZED?  IF YES, GIVE NAME & ADDRESS OF INSTITUTION(S) AND PERIOD OF CONFINEMENT  YES								
IS DEPENDENT ELIGIBLE FOR CARE UNDER FEDERAL, STATE, LOCAL LAW, MEDICARE?  YES  NO	IF YES, GIVE DETAILS				EFFECTIVE D PART A	EFFECTIVE DATE OF MEDICARE ELIGIBILITY: PART A PART B		
WAS OR IS DEPENDENT EMPLOYED FOR WAGES?  YES DATES OF LAST EMPLOYMENT  NO FROM: TO:	NAME AND ADDRESS OF CURRENT OR LAST EMPLOYER			LOYER	IS DEPENDEN  ☐ YES	IS DEPENDENT A FULL-TIME STUDENT?  ☐ YES ☐ NO		
SCHOOL ATTEND(ED) (ING)					EDICAL LEAVE FROM SCHOOL?  VATE OF START OF LEAVE:			
DOES DEPENDENT PLAN TO RETURN TO SCHOOL?  YES RETURN TO SCHOOL DATE:  NO	SIGNATURE OF PARENT OR GUARDIAN					DATE SIGNED		
If the determination is a one-year Temporary Approval, a new application must be completed and returned for review <b>prior</b> to the approval termination date.								
SECTION II — TO BE COMPLETED BY PHYSICIAN								
				E DID THE Y BEGIN?	ION THE CCIDENT? NO VT:			
DIAGNOSIS: DEPENDENT'S IQ If applicable:								
CLINICAL FINDINGS/SEVERITY OF ILLNESS:								
FUNCTIONAL STATUS:								
CURRENT TREATMENT:								
PLEASE ATTACH SUPPORTING DOCUMENTATION  IN YOUR OPINION WILL THIS CHILD EVER BE CAPABLE OF SELF-SUSTAINING EMPLOYMENT?								
SIGNATURE OF ATTENDING M.D.	SPE	ECIALTY	ADDRES		_	DATE SIGNED		
FOR OFFICIAL USE ONLY								
☐ PERMANENT APPROVAL ☐ SIGNATURE OF MEDICAL DIRECTOR ☐ TEMPORARY APPROVAL (One Year) ☐ DENIAL						DATE SIGNED		