RESEARCH FOUNDATION CUNY

RESEARCH FOUNDATION
of The City University of
New York 230 West 41st
Street
New York, NY 10036-7207

RFCUNY Disabled Dependent Overage Health Insurance Coverage Form

RFCUNY Employee Number: _____

Date of Request: _____

Dear RFCUNY Member:

We are glad to confirm that our family contracts provide medical benefits for mentally challenged or physically disabled dependents over age 26, provided that the dependent 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,

Office of Human Resources
Research Foundation of CUNY

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 OVER 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 ANTHEM

INSTRUCTIONS:

CONTRACT HOLDER — 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	SEX ☐ M ☐ F	ID NUMBER OF DEPENDENT CHILD	DEPENDENT'S D.O.B. MONTH DAY YEAR	DEPENDENT's MARITAL STATUS ☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ DIVORCED
ADDRESS OF DEPENDENT CHILD (NO. & STREET, CITY, STATE, ZIP CODE, APT. NO.)			MEMBER ID NUMBER	GROUP NUMBER
WAS DEPENDENT CHILD EVER INSTITUTIONALIZED? ☐ YES ☐ NO	IF YES, GIVE NAME & ADDRESS OF INSTITUTION(S) AND PERIOD OF CONFINEMENT			
IS DEPENDENT ELIGIBLE FOR CARE UNDER FEDERAL, STATE, LOCAL LAW, MEDICARE? ☐ YES ☐ NO	IF YES, GIVE DETAILS		EFFECTIVE DATE OF MEDICARE ELIGIBILITY: PART A PART B	
WAS OR IS DEPENDENT EMPLOYED FOR WAGES? ☐ YES ☐ NO DATES OF LAST EMPLOYMENT FROM: TO:	NAME AND ADDRESS OF CURRENT OR LAST EMPLOYER		IS DEPENDENT A FULL-TIME STUDENT? ☐ YES ☐ NO	
SCHOOL ATTEND(ED) (ING)	DATE FROM: TO:	IS DEPENDENT ON MEDICAL LEAVE FROM SCHOOL? ☐ YES ☐ NO DATE OF START OF LEAVE:		
DOES DEPENDENT PLAN TO RETURN TO SCHOOL? ☐ YES ☐ NO RETURN TO SCHOOL DATE:	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 **prior** to the approval termination date.

SECTION II — TO BE COMPLETED BY PHYSICIAN

IS DEPENDENT PRESENTLY INCAPABLE OF SELF-SUSTAINING EMPLOYMENT BY REASON OF: ☐ MENTAL ILLNESS ☐ MENTAL RETARDATION ☐ DEVELOPMENTALLY DISABLED ☐ PHYSICAL HANDICAP	WHAT DATE DID THE INCAPACITY BEGIN?	WAS THE CONDITION THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO DATE OF ACCIDENT:

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? ☐ YES ☐ NO ☐ NOT AT THIS TIME

SIGNATURE OF ATTENDING M.D.	SPECIALTY	ADDRESS	DATE SIGNED

FOR OFFICIAL USE ONLY

☐ PERMANENT APPROVAL ☐ TEMPORARY APPROVAL (One Year) ☐ DENIAL	☐ SIGNATURE OF MEDICAL DIRECTOR	DATE SIGNED

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