

# Request for Continuation of Coverage for Disabled Children



Please Note: This form is to be completed by the participant/member and sent to the address on page 2.

## EMPLOYEE INFORMATION

Participant/Member Name (Please Print):

Participant/Member ID #:

Employer Group (Please Print):

## SECTION A

### This certifies that:

Dependent name (Please Print):

Dependent Date of Birth:

1. is my unmarried child
2. cannot engage in any substantial gainful activity because of a physical or mental condition that has lasted or can be expected to last continuously for at least a year or can lead to death; and
3. is principally dependent upon me for support and maintenance.

## SECTION B

I request continuance of insurance, which would otherwise terminate on attainment of the age limitation of the group policy.

## SECTION C

I understand that no liability for claims exists with respect to any period prior to the receipt of this form.

## SECTION D

### I attest and/or consent to the following:

1. My child's attending physician (name and address indicated below) may be contacted to obtain information concerning my child's incapacity.

Physician Name:

Physician Address:

2. The information given above is correct to the best of my knowledge and belief.
3. I understand that enrollment for this child under my coverage may remain in force only if the disability and dependency exist, and while my coverage is of the type which may include such a dependent child. I further understand that recertification may be required as to eligibility for continuing coverage from time to time as often as it is deemed reasonable.
4. I recognize that any cost associated with the release of this medical information will be at my expense.
5. Fraudulent information is cause for immediate or retroactive termination of coverage.

Participant/Member Signature):

Date:

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Please Note: This form must be signed or cosigned by an MD, DO, or the equivalent, and sent to the address below.

## PATIENT INFORMATION

Patient Name (Please Print):

Patient Date of Birth:

*A patient is disabled if he/she cannot engage in any substantial gainful activity because of a physical or mental condition that has lasted or can be expected to last continuously for at least a year or can lead to death.*

## PLEASE CHOOSE ONE FOR EACH BELOW:

### This certifies that:

Dependent name:

Dependent Date of Birth:

1. Is the patient prohibited from engaging in any substantial gainful activity because of a physical or mental condition?
2. Has the patient's condition lasted or can be expected to last continuously for at least a year or lead to death?
3. Is there is any reasonable probability that the patient will ever be capable of self-support?

## SECTION D: PLEASE STATE THE PATIENT'S PHYSICAL AND/OR PSYCHOLOGICAL DIAGNOSIS

## SECTION E: HOW LONG HAS THE PATIENT BEEN UNDER YOUR ONGOING TREATMENT?

## SECTION F: WHAT IS THE PATIENT'S ANTICIPATED FUTURE COURSE AND DURATION OF TREATMENT?

Signature:

Date:

Address:

**YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.**

### PLEASE RETURN COMPLETED FORM TO:

Great Bay Administrators, 37 Industrial Drive Exeter, NH 03833,  
or submit through our secure portal