NORTHERN BUCKEYE Health PLAN
NW Division of OHI

Certificate of Impairment
Children's Provision

Employee Name:	Employer Name:

Name of Impaired Child:	Date of Birth:	Social Security Number:

Please review the following statements:

This is to certify that the above listed child fulfills the following requirements:

(1) is my unmarried child;
(2) is living in my home;
(3) is mentally and/or physically incapable of earning his/her own living;
(4) became so incapable prior to the attainment of the limiting age for a child's coverage under this plan (26); and
(5) is financially dependent upon me for 100% of their support and maintenance (not including government assistance).

With respect to this child, I am requesting the continuance of the dependent's coverage clause which would otherwise terminate on the date of this individual becoming ineligible under my group plan because of age.

My child IS or IS NOT approved for Social Security, SSI and/or Medicare. (Please circle)
If your child is eligible for any of the above benefits, please submit proof of other coverage.

I understand that the company reserves the right to request a physician's examination of my child. I also understand that if this continuance of coverage is approved, such coverage for this child would terminate as of the date of recovery, or if any of the above conditions are no longer satisfied. I agree to notify Northern Buckeye Health Plan immediately should this happen.

The above-named child has been covered by me as an eligible dependent since: | Date:

By signing below, I do solemnly swear and declare the above statements to be true to the best of my knowledge.

Signature of Employee:	Social Security Number:	Date:

Please return to:

Administrative Support Team
ast@planmanagementservice.com or mail to

209 NOLAN PARKWAY
ARCHBOLD, OHIO 43502