Certificate of Disability for the Handicapped Children's Provision Application for Continuation of Coverage

Employer Name:	Group Number:

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

Please review the following statement and complete item (4):

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

(1) is my unmarried child;
(2) is mentally and/or physically incapable of earning his/her own living;
(3) became so incapable prior to the attainment of the limiting age for a child's coverage under this plan; and
(4) is financially dependent upon me for _____% 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.

I understand that the company reserves the right to examine my child, at its own expense, and 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 four conditions are no longer satisfied.

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

I hereby authorize any physician, hospital, pharmacy, insurance company, employer, or organization to release any information regarding medical history, treatment, or disability to Northern Buckeye Health Plan, for the purpose of validating and determining coverage available in connection with this application. Data without personal identification may be extracted for use in statistical studies.

New form or update may be required every five (5) years.

Signature of Employee	Social Security Number:	Date:
Signature of Employer		Date:

MAIL TO NORTHERN BUCKEYE HEALTH PLAN
209 NOLAN PARKWAY
ARCHBOLD, OHIO 43502

Attending Physician's Statement of Disability

Name of Patient:		Address:	
City:	State:	Zip Code:	Date of Birth:

History

• When did symptoms first appear or accident happen?	Month:	Day:	Year:
• Date patient ceased work because of disability. (if applicable)	Month:	Day:	Year:
• Had patient ever had same or similar condition? If yes, state when and describe. _____ Yes _____ No	Date:	Description:	

Present Condition

• Did this incapacity exist prior to the dependent's 26th birthday? _____ Yes _____ No			
• Subjective symptoms:	Describe:		
• Objective symptoms: (include results of EKG's, current X-rays, or any other special tests)	Describe:		
• Is the patient: _____ Ambulatory _____ Bed Confined _____ House Confined _____ Hospital Confined			

Diagnosis:

Treatment

• Date of first visit	Month:	Day:	Year:
• Date of last visit	Month:	Day:	Year:
• Frequency of visits:	Weekly:	Monthly:	Other:
• When did you last examine this patient:	Month:	Day:	Year:
• Degree of psychiatric impairment:	_____ None	_____ Mild	_____ Severe
• Degree of physical impairment:	_____ None	_____ Mild	_____ Severe
• Is this patient capable of holding self-sustaining employment at this time? If yes, please comment: _____ Yes _____ No	Comment:		

Name of Hospital(s)

• Please name hospital(s), if ever admitted as an in-patient:	Admission Date(s):	Discharge Date(s):

Progress

_____ Recovered _____ Improved _____ Unimproved _____ Retrogressed

Attending Physician Information & Signature

Signature: (Attending Physician)		Degree:
Social Security or Tax I.D. Number:	Date:	
Street Address:		
City or Town:	State:	Zip Code:

March 6, 2020

Mbr Name
Address
City, ST ZIP

RE: Group:
Employee:
Dependent:
DOB:

Dear:

Northern Buckeye Health Plan (NBHP) has received your request for information regarding a continuation of coverage for your dependent, _____. Before a final determination can be made, we ask that you complete the attached Certificate of Mental and/or Physical Incapacitation and return it to NBHP within thirty-one (31) days of the date of this letter. Please also provide a statement from your dependent's primary physician or doctor attesting to the mental and/or physical incapacitation.

Please be advised, if the continuance of coverage is approved, such coverage continues during the period you remain covered under the Plan and as long as the dependent remains incapacitated and unmarried.

Thank you for your cooperation in this matter. If you have any questions, please do not hesitate to contact us directly at (419)-267-2806 or 1-855-664-0012.

Sincerely,

The Administrative Support Team

PH (419)-267-2806
FAX (419) 267-5262

Enclosure