

COVERAGE FOR A MENTALLY RETARDED OR PHYSICALLY HANDICAPPED CHILD

Under the provisions of Section 1751.14. of the Ohio Revised Codes and Section 550.1410 and 500.2264 of the Michigan Compiled Laws annotated:

- (A) Any policy, contract, or agreement for health care services authorized by this chapter that is issued, delivered, or renewed in this state and that provides that coverage of an unmarried dependent child will terminate upon attainment of the limiting age for dependent children specified in the policy, contract, or agreement, shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child if the child is and continues to be both:
1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap:
 2. Primarily dependent upon the subscriber for support and maintenance.
- (B) Proof of incapacity and dependence for purposes of division (A) of this section shall be furnished to the health-insuring corporation within thirty-one days of the child's attainment of the limiting age. Upon request, but not more frequently than annually, the health insuring corporation may require proof satisfactory to it of the continuance of such incapacity and dependency.

INSTRUCTIONS

SUBSCRIBER - Please complete Section I on the other side of this form.

- Give this form along with the enclosed return envelope to the attending physician.

ATTENDING PHYSICIAN - Please complete the physician's section on the other side of this form and return to Paramount.

APPLICATION FOR CONTINUATION OF COVERAGE

For a child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who has reached the limiting age for dependent children specified in the contract.

Please read conditions of eligibility on reverse side of this form. Please type or print.

Section I - To Be Completed By Subscriber

Dependent Child's Name (Last, First, Initial) Child's Sex Child's Birthdate Relationship to Subscriber
 Male _____ Mo Day Yr
 Female _____

Subscriber's Address (Number, Street, City, State & Zip Code)

Child's Marital Status Date Child's Disability Is Child Permanently residing in Your Household?
 Single _____ Widowed _____ Occurred Yes _____ If "No" Explain
 Married _____ Divorced _____ No

Is Child Dependent on You For Support? If "Yes" What Part of Support Do You Contribute? Was Child Taken as a Dependent On Your Last Income Tax Return? Was Child Ever Employed?
 Yes _____ No _____ (% of Total) Yes No Yes No

Is Child Employed Now? If Answer to Either of the Last Two Questions is "Yes", Give Names (s), Address(es) of Employers(s) and Date(s) Employed:
 Yes _____ No _____

Is Dependent Eligible for Any Other Care Under Federal, State or Local Law? If "Yes" Give Details:
 Yes _____ No _____

Do You or Your Spouse Have Other Health Care Coverage? If "Yes" Give Name and Address of Insurance Company:
 Yes _____ No _____

I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge. I hereby authorize any physician or other person who has attended my above named dependent child or who say hereafter attend or examine such child to disclose any knowledge or information thereby acquired by him to Paramount.

Subscriber Date Signature of Subscriber Soc. Sec. No. of

Section II - To Be Completed By Attending Physician

Has Child's Disability Existed Continuously up to the Present? Date Child's Disability Occurred What is Child's IQ? Prognosis (Estimate months or years) Is Child Now Incapable of Self-support because of the Disability?
 Yes _____ No _____ Yes No

Nature of Disability (Please give as much detail as practicable) - Use other side of sheet if necessary.

Date Signature of Physician Physician Address
 To Physician: Please return form directly to Paramount Health Care