

# Request to Extend Limiting Age for Mentally Retarded, Severely Mentally Ill, or Physically Handicapped Dependent Child

## SECTION I - TO BE COMPLETED BY EMPLOYEE (Please type or print clearly)

Please attach this to a completed form ADM 4729 - Affidavit of Dependent Status. Return completed forms to your payroll/personnel officer. This form will be sent to your health plan for approval.

Employee's last name	Employee's first name	M.I.	SSN
Dependent child's name		Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Birthday ____/____/____ Mo / Day / Year
Employee's address (number, street, city, state & Zip code)			
I certify that information provided on this application is correct to the best of my knowledge and authorize release of any information requested below with respect to this certification.			
Employee's signature		Date of signature	

## SECTION II - MENTALLY RETARDED DEPENDENT CHILD

Please attach a school or other report documenting the dependent's mental retardation. Skip Section III.

## SECTION III - SEVERELY MENTALLY ILL OR PHYSICALLY HANDICAPPED DEPENDENT TO BE COMPLETED BY ATTENDING PHYSICIAN OR MENTAL HEALTH PROVIDER

Date of onset dependent's condition?	Has condition existed continuously to present?	Prognosis: Is the condition: Permanent: YES___ NO___ Temporary: YES___ NO___  If temporary, estimate either months ___ or years___	Is dependent now incapable of self-support because of the condition?
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**Please state the nature of dependent's condition and diagnosis - please give as much detail as possible. Attach a separate sheet if necessary.**

\_\_\_\_\_  
Physician's or mental health provider's name Signature Date

\_\_\_\_\_  
Address (Number, Street, City, State & Zip)

## COVERAGE FOR A MENTALLY RETARDED, SEVERELY MENTALLY ILL, OR PHYSICALLY HANDICAPPED DEPENDENT

A mentally retarded, severely mentally ill or physically handicapped child is an eligible dependent and may not be terminated as a dependent under a family health insurance contract upon attaining the limiting age of the certificate, provided the dependent:

- ◆ Is not married;
- ◆ Became mentally retarded, severely mentally ill or physically handicapped before age 23 for dependent children specified in the certificate;
- ◆ Is incapable of self-sustaining employment by reason of mental retardation, severe mental illness or physical handicap which commenced prior to age 23 for dependent children specified in the certificate; and
- ◆ Is primarily dependent upon the policyholder for support and maintenance;

### AND PROVIDED THAT

Proof of such incapacity and dependence must be documented in forms ADM 4729 and ADM 4730. The employee must submit the forms to his/her agency's payroll or personnel office to establish coverage between ages 19-23 and within thirty-one days of the dependent's attainment of age 23. The limiting age for dependent children is 19, or 23 if the dependent is a student at an accredited school.)

**WARNING:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

***Attention -- Payroll/Personnel Office: Forward this form to the employee's health plan eligibility contact.***