KelseyCare
administered by BOON-CHAPMAN

Request for Certification for a Mentally or Physically Incapacitated Dependent Child

SECTION 1 – Employee and Dependent Child Information:

Name of Employee:	Street Address:	City:	State / Zip:
Employee's Social Security Number:	Employee's Certificate Number:	Name of Employer:	Division Number:
Name of Dependent Child to be Covered:	Street Address if different:	City:	State / Zip:
Dependent Child's Birth Date: Mo Day Yr	Dependent Child's Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed		

Is the Dependent Child Employed for Wages? ( ) No ( ) Yes
If yes, give name of employer and approximate number of hours worked per week:

Employer Name: _____ Number of Hours Worked: _____

Is the Dependent Child confined to an institution or attending school? ( ) No ( ) Yes
If yes, give name of institution or school and date of admission:

Name of Institution or School: _____ Date of Admission: _____

Is the above-named dependent receiving Medicare or Medicaid benefits? ( ) No ( ) Yes
If yes, please circle which benefits are being received below and include copy of:

- Medicare Card or Medicaid Card

Has the Dependent Child applied for SSI benefits? ( ) No ( ) Yes Date of Application: _____

What is the length of time that this disability has existed? _____ Start Date: _____

SECTION 2 – Parent or Legal Guardian Signature:
I am requesting that the above mentioned Child be included under my Group Health Plan coverage. I understand that this Child may be covered only so long as:
* The Child is incapable of self-support because of a physical or mental incapacity which existed prior to age twenty-six (26), and
* I furnish more than one-half of this Child's support.

I further understand that:
* It is the responsibility of the applicant to notify Boon-Chapman of any change in the status of the dependent's incapacity, and that
* Boon-Chapman shall have the right to require recertification as to the eligibility for continuation of coverage as an incapacitated dependent.

If you have additional questions, or need assistance in completing this form, please contact your group's benefit Administrator or the Customer Service number listed on your Boon-Chapman ID Card.

I certify that the above statements are true and complete to the best of my knowledge and belief.

Employee Signature: _____ Date: _____

Before you return the certification, please:
- □ Complete and verify all information and sections of this application;
- □ Verify you have read and understood all sections;
- □ Supply written documentation of prior coverage up to the effective date if Dependent is over 26 years of age and you are transferring from another insurance carrier;
- □ Submit this form to the dependent child's attending physician for completion and signature.

Please return to the address below:
Boon-Chapman, Attn: Eligibility Manager, PO Box 9201, Austin, TX 78766

SECTION 2 – Child's Attending Physician Certification (to be completed by Physician)

Date of First Examination ____/____/____ Date of Last Examination ____/____/____ Frequency of Visits: _____
Mo. Day Year Mo. Day Year
(must be within one year to consider this application)
Diagnosis/Disability (Include ICD9 Code-*Required*) _____

Clinical Information:
(Medical summary documenting all items listed can be attached to form in lieu of completing this section)

Onset (specify date) _____/_____/_____
Mo. Day Year

Test/Data Establishing Diagnosis
_____
_____

Pertinent Clinical Findings and Course (including recent lab data)
_____
_____

Other Medical Problems _____

Current Medications _____

Treatment Plan (include expected duration)
_____
_____

If the disability is psychiatric, please complete this section also (or address these items in your narrative report)

Complete DSMTV diagnosis *required with descriptors, codes, and severity specifiers:* Axis I Axis II Axis III Axis IV Axis V GAF, current: GAF, highest, past yr	Is the dependent financially competent? ( )No ( ) Yes Is the dependent fully compliant with treatment? ( ) No ( ) Yes If non compliant, how not? If not, might the prognosis below be different if he/she were compliant? ( )No ( ) Yes Has the dependent been hospitalized for a psychiatric condition? ( )No ( ) Yes Dates and facility: What is the nature and degree of the dependent's impairment in his/her capacities for: daily activities? task performances? social interaction?

If disability involves developmental delay or intellectual deterioration, has IQ testing been performed?
( ) No ( ) Yes Results _____ Date performed _____

If not, what intellectual functions can be performed, (e.g. math, reading, comprehension, memory skills) _____

Is the dependent ____ Ambulatory _____ Non Ambulatory _____ Bed Confined _____ Wheelchair Confined
_____ House Confined _____ Hospital/Institution Confined - Facility Name _____

Is the dependent independently capable of supporting himself/herself through gainful employment? ( ) No ( ) Yes

Prognosis of Totally Disabling Condition:
_____ Permanent and Total _____ Permanent and Partial (%)
_____ Temporarily Disabled with Expected Return to Partial Function (%) *Return* Date _____/_____/_____
Mo. Day Year
_____ Temporarily Disabled with Expected Return to Full Function (%) *Return* Date _____/_____/_____
Mo. Day Year

I certify that the above statements are relative to the disabled dependent named are true and complete to the best of my knowledge and belief.

_____/_____/_____ _____
Mo. Day Year (Signature)

Physician's Name _____
Physician's Specialty _____
Physician's Address _____
License Number _____