

IMPORTANT: PLEASE COMPLETE APPLICATION FORM CAREFULLY, INCORRECT OR MISSING INFORMATION MAY CAUSE DELAY IN CLAIM PAYMENTS.

MEMBER INFO - PLEASE PRINT IN INK:

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY #
STREET NUMBER AND NAME		(c/o Info.)	COUNTY
CITY	STATE	ZIP	

COVERAGE FOR A HANDICAPPED PERSON 19 YEARS OF AGE OR OLDER

A handicapped person may be continued as a dependent under a family contract, without additional cost, after reaching age 19, provided the person:

*provides certification from a physician of the disability *is unmarried *is unable to engage in gainful activity due to a mental or physical handicap *condition is expected to continue for a long and indefinite time.

I REQUEST CONTINUATION FOR MY DEPENDENT NAMED BELOW WHO IS TOTALLY DISABLED

<u>DEPENDENT'S LAST NAME</u>	<u>FIRST</u>	<u>Sex</u> M/F	<u>BIRTHDATE</u> Month / Day / Yr	<u>MARITAL STATUS</u> <input type="checkbox"/> Single <input type="checkbox"/> Married	CHECK BOX(es) IF DEPENDENT HAS MEDICARE Part A Eff. Date _____ Part B Eff. Date _____
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Percent Support Provided By Subscriber	DEPENDENT'S ADDRESS
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All information furnished heron is true and complete to the best of my knowledge.

Date _____ Signature X _____

THIS SECTION TO BE COMPLETED BY PHYSICIAN:

PHYSICIAN'S NAME	PHYSICIAN'S ADDRESS
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Is Dependent Capable of Self-Support? YES NO DISABILITY IS MENTAL PHYSICAL

Date Dependent Became Incapable of Self-Support _____ Date Dependent was last treated _____

Prognosis (Estimate in Months or Years) _____ Dependent is now confined at Home Institution

Name of Institution _____

Diagnosis of condition causing disability (indicate degree of severity): _____

Date: _____ Signature of Physician _____

DO NOT WRITE IN THIS SPACE	
RECEIVED	RECEIVED - EDP