



STATE OF LOUISIANA
 DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS



**REQUEST FOR CONTINUATION OF HEALTH COVERAGE FOR
 INCAPACITATED DEPENDENT CHILD**

Employee/plan enrollee instructions:

- Complete sections 1 through 6 on this form.
- Print the information requested, except for the signature section.
- Obtain your incapacitated dependent child’s Attending Physician’s Statement.
- Forward this completed form to:

Office of Group Benefits Eligibility Division
 Post Office Box 44036
 Baton Rouge, LA 70804
 FAX: 225-342-9917

Note: OGB has the right to:

- Require proof of the continuation of the dependent child’s incapacity.
- Examine or require examination of your dependent child (at his/her/your own expense) as often as OGB may deem necessary while the continued coverage is effective.

Continuation of coverage will automatically terminate the last day of the month in which any one of the following events first occurs:

- Cessation of your dependent child’s incapacity.
- Failure to provide timely proof of your dependent child’s continuing incapacity.
- Failure to have any OGB required exam.
- Termination of your dependent child’s coverage for reasons other than reaching the maximum age.

1. Plan Enrollee Information	Name	Social Security Number
	Address (street, city, state, zip code)	
2. Plan Enrollee Certification	I hereby certify that, to the best of my knowledge and beliefs, the statement and answers made on this form are complete and correct. I understand that continuation of coverage for an incapacitated dependent child is subject to approval by the Office of Group Benefits based on the applicable health plan and the documentation submitted to OGB in support of this request for continued coverage.	
	_____	_____
	Plan Participant’s Signature	Date
3. Plan Enrollee Notice	<u>NOTICE</u>	
	If you enroll someone that is not eligible for coverage, it will be considered an act of fraud or intentional misrepresentation of material fact. The issuance of continued coverage is conditioned on the representations and statements contained in this required form. All representations made are material to the issuance of this coverage. Any information provided on the application or enrollment form, or intentionally omitted therefrom, as to any proposed or covered dependent child, shall constitute an intentional misrepresentation of material fact. A plan enrollee’s coverage may be rescinded retroactively to the effective date of coverage for fraud or intentional misrepresentation of material fact.	



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4. Dependent Child Information	Name	Birth Date (MM/DD/YY)	Social Security Number
	When did the incapacity start?		
	<input type="checkbox"/> Mental Incapacity: (Date) <input type="checkbox"/> Physical Incapacity: (Date)		
	<u>School History:</u>		
	Have you been attending school or a training facility since reaching age 26? <input type="checkbox"/> yes <input type="checkbox"/> no		
	<u>Work History:</u>		
	Have you been working? <input type="checkbox"/> yes <input type="checkbox"/> no		
	If yes, complete the following:		
	Employer Name	Employment Dates	Hours worked Weekly
			Hourly Wage
			Description of Duties
	1. _____		
	2. _____		
	3. _____		
	4. _____		
	(For additional work experience or information, attach an 8½ X 11 paper. Use same format as work experience on this application.)		
	<u>Living Arrangement:</u>		
	Do you live with the plan enrollee? <input type="checkbox"/> yes <input type="checkbox"/> no		
	If no, where do you live? _____ _____ _____		
	<u>Financial Support:</u>		
	Does the plan enrollee claim you as a dependent for federal income tax purposes? <input type="checkbox"/> yes <input type="checkbox"/> no		
	Does the plan enrollee provide more than one-half of your financial support? <input type="checkbox"/> yes <input type="checkbox"/> no		
	If no, please explain: _____ _____ _____		
5. Dependent Child Signature	I acknowledge, agree, and declare that the foregoing information is true and correct.		
	Signature and date of dependent child or representative: _____ Date		
	Printed name of signing party (dependent child or representative): _____		
	Signing party's relationship to dependent child: _____		
6. Attending	Name		



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Physician Information	Address (street, city, state, zip code)
7. Attending Physician's Statement	<p>Telephone Number, including the area code: ()</p> <p><u>This part is required to be completed by your doctor. Please complete and sign the attached Medical Release Authorization and submit it to your doctor with this form:</u></p> <p>The following questions may be answered on this form or on a separate sheet of paper. This form is required to be submitted with your reply.</p> <p>1. Exact diagnosis and any related condition, symptoms, disease or disease processes:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>2. Date first diagnosed: (MM/DD/YYYY) _____</p> <p>3. Treatment rendered, including dates and any medications: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>4. Restriction of activities as a result of condition: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>5. Current condition: _____</p> <p>6. Prognosis for recovery: _____</p> <p>_____</p> <p>_____</p> <p>7. Attach a copy of pathology report, if applicable.</p> <p>8. Include any paperwork demonstrating permanent disability.</p>



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Physician Attestation:

I, _____ to the best of my knowledge, attest that the dependent child
(Printed First and Last Name of Doctor)
_____ is incapable of self-sustaining employment.
(Printed First and Last Name of Child)

9. Doctor's signature and date: _____

10. Printed or stamp name of Doctor: