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	**NOTICE** 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 A plan enrollee's coverage may be rescinded retroactively to the effective date of coverage for fraud or intentional misrepresentation of material fact.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? ❑ Mental Incapacity: (Date) ❑ Physical Incapacity: (Date)		
	School History: Have you been attending school or a training facility since reaching age 26? ❑ yes ❑ no		
	Work History: Have you been working? ❑ yes ❑ 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.)		
	Living Arrangement: Do you live with the plan enrollee? ❑ yes ❑ no If no, where do you live?		
	Financial Support: Does the plan enrollee claim you as a dependent for federal income tax purposes? ❑ yes ❑ no Does the plan enrollee provide more than one-half of your financial support? ❑ yes ❑ 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)
	Telephone Number, including the area code: ( )
7. Attending Physician's Statement	**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:** 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. 1. Exact diagnosis and any related condition, symptoms, disease or disease processes: _____ _____ _____ _____ 2. Date first diagnosed: (MM/DD/YYYY) _____ 3. Treatment rendered, including dates and any medications: _____ _____ _____ _____ _____ 4. Restriction of activities as a result of condition: _____ _____ _____ _____ _____ 5. Current condition:_____ 6. Prognosis for recovery: _____ _____ _____ _____ _____ 7. Attach a copy of pathology report, if applicable. 8. Include any paperwork demonstrating permanent disability.

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: