Application for Coverage or Continuation of Coverage for Adult Dependent Who is Disabled

Reply to: OhioHealthy, P. O. Box 2582, Hudson, OH 44236-2582
Plan: OhioHealthy

Employee Information

Please fill out and sign this portion of the form. Have your dependent's doctor complete the Attending Physician's Statement and return it promptly to the Office Address in the upper right-hand corner. Failure to file timely notice may affect your application.

☐ Application for Dependent Coverage

☐ Application for Continuation of Dependent Coverage
☐ Application for Reinstatement of Dependent Coverage

Employee Name	Employee Address	Telephone

Employer Name and Address:	

Dependent Information

Dependent Name	Date of Birth	Marital Status	Education-highest grade attained

Date of first treatment for this disability	Date of first unable to work / disabled	Name and address of attending physician

Has dependent engaged in any self-sustaining employment since disability commenced?	Does Dependent receive income or medical benefits from any other source? (Explain below)
☐ **No** ☐ **Yes.** (list employment dates)	

Name and address of dependent's employer:

The above answers are true and complete. I authorize any employer, insurer, medical prepayment plan or hospital or medical service plan, physician or other medical professional, hospital or other medical or custodial care institution, consumer reporting agency, or attorney to release to or obtain information from Employee's Employer regarding any employment, medical or benefit payment information that may be required to determine eligibility for coverages and further authorize said company, person or plan, to disclose any personal or claim information required for medical case study or review. A photocopy of this authorization shall be as valid as the original. I have a right to receive a copy upon request.

X_____ Dependent's Authorized Representative Signature	_____/____/_____ Date
X _____ Employee's Signature	_____/____/_____ Date

Attending Physician's Statement

Dear Doctor: Your patient,	
is a dependent of	
employed by	

This report requests evidence of the disabled status of your patient, to assist us in determining eligibility for group coverage beyond the dependent age limit. "Disabled status" means the incapacity to achieve self-support through employment at a minimum level because of any condition defined by contract or law as a disability. Please include sufficient details of history, physical and diagnostic findings, clinical course, therapy and response, and vocational plans to enable us to make a determination of the patient's incapacity.

The completed form should be returned to the address listed on the front of the form.

Patient History

Age: **Date symptoms first appeared, or accident happened:**

Is patient totally disabled? ☐ **Yes** ☐ **No**

Date patient became disabled:

Has patient been continuously disabled?
☐ **Yes.**
☐ **No (explain)**

Diagnosis (Nature of disability, including complications)

Subjective symptoms:

Objective findings (including current signs, laboratory data & X-ray results, EKG, pulmonary function studies, etc.).

Dates of Treatment

Date of first visit: / / **Date of last visit: / /**

Frequency: ☐ **Weekly** ☐ **Monthly** ☐ **Other (specify)**

Nature of Treatment

Including educational and vocational training, surgery, therapy and medications, etc.

Progress

Patient has: ☐ Recovered ☐ Improved ☐ Stabilized ☐ Retrogressed

Patient is: ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

If patient has been hospital confined, give name and address of hospital:

Confinement dates: From: / / Through: / /

Is this patient capable of self-sustaining employment? ☐ Yes ☐ No (explain)

Physical Impairment

- ☐ Class 1 – No limitation of functional capacity; capable of heavy physical activity. No restrictions (0-10%)
- ☐ Class 2 – Slight limitation of functional capacity; capable of light manual activity. (15-30%)
- ☐ Class 3 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (35-55%)
- ☐ Class 4 – Marked limitation. (60-70%)
- ☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary) activity. (75-100%)

Remarks: _____

_____

Intellectual Impairment

- ☐ None (IQ 85 and above)
- ☐ Borderline (IQ 71 to 84)
- ☐ Mild (IQ 50 to 70)
- ☐ Moderate (IQ 35 to 49)
- ☐ Severe/Profound (IQ 34 and below)

Remarks: _____

Social Impairment (personal/social skills)

- ☐ Class 1 – able to function under stress and engage in interpersonal relations (no limitations)
- ☐ Class 2 – able to function in most stress situations and engage in most interpersonal relation (slight limitation)
- ☐ Class 3 – able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- ☐ Class 4 – unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- ☐ Class 5 – significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks: _____

Prognosis

Do you expect a fundamental or marked improvement in the future? ☐ Yes ☐ No

If yes, when will the patient recover sufficiently to become employed?

☐ 1 month or less ☐ 1-3 months ☐ 3-6 months ☐ 6-9 months ☐ 1 year or longer

If no improvement expected, please explain:

_____

_____

Cardiac (if applicable)

Functional capacity limitation (American Heart Assoc.): ☐ Class 1 (none) ☐ Class 2 (slight) ☐ Class 3 (marked) ☐ Class 4 (complete)

Blood Pressure (last visit): _____

Remarks and Suggestions (Please print)

Remarks:

_____

_____

Physician signature is required for this form to be valid	
Physician Name (Please print):	
Address (street, city, state, zip):	
Telephone (include area code):	
Fax (include area code):	
Any person who knowingly and intentionally tries to defraud this Attending Physician's Statement is guilty of a crime. A copy of this form is as valid as the original	
X_____ Physician Signature NPI Number	_____/____/_____ Date