HEALTH DESIGN PLUS

Application for Coverage or Continuation of Coverage for Handicapped Children

Reply to: Health Design Plus, 1755 Georgetown Road, Hudson, OH 44236

Plan: ____________________________

Participant 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 Claim 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	Social Security Number	Employee Address	City, State, Zip Code	Telephone (Area Code)

Employer Name and Address

Dependent Information

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

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

Has dependent engaged in any self-sustaining employment since handicap Commenced? ☐ No ☐ Yes – List dates of employment	Does Dependent receive income or medical benefits from any other source? (Explain)
Name and address of dependent's employer	Current Medical Benefits ☐ No ☐ Yes – List coverage

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 any employment, medical or benefit payment information that may be required to determine eligibility for coverage and further authorize said company, person or plan, to disclose any personal or claim information required for medical case study or review.

X	X
Patient's or authorized Person's Signature	Date

Employer Information

Employer: Please complete your section below, have the employee complete the above section and instruct employee to have dependent's doctor complete the attending physician's statement and send it to the address in the upper right corner.

Employee Name	Date Employed	Dependent Name

Effective date of employee coverage (mm/dd/yyyy)	Effective date of dependent coverage (mm/dd/yyyy)

If dependent coverage was previously terminated, date terminated (mm/dd/yyyy)

Name of Employer

Date	By (print)	Signature	Title

Attending Physician's Statement

Dear Doctor:

Your Patient ____ is a dependent of ____

employed by____

This report requests evidence of the Handicapped Child Status of your patient, to assist us in determining eligibility for group coverage beyond the dependent age limit. "Handicapped Child 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 handicap**. 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 Health Design Plus at the address listed on the first page of the form, in the upper right corner.

Patient History

Age

Date symptoms first appeared or accident happened (mm/dd/yyyy)

Date patient became incapacitated by handicap(mm/dd/yyyy):

Has patient been continuously incapacitated?:

☐ Yes ☐ No - Explain

Is patient totally disabled? ☐ Yes ☐ No

Diagnosis (Nature of Handicap, 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 (mm/dd/yyyy) Date of last visit (mm/dd/yyyy)

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 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

Remarks and Suggestions-(Please print) Physician signature is required for this form to be valid

Remarks:

Physician Name (Please print):

Address (street, city, state, zip):

Telephone Number (area code): Fax number (area code):

The above answers are true and complete
A copy of this form is as valid as the original.

X **X**

Physician Signature **Date**