Certificate of Disability for the Handicapped Children's Provision Application for Continuation of Coverage

Employer Name:	Group Number:

Name of Handicapped Child:	Date of Birth:	Social Security Number:

Please review the following statement and complete item (4):

This is to certify that the above listed child fulfills the following requirements:

(1) is my unmarried child;
(2) is mentally and/or physically incapable of earning his/her own living;
(3) became so incapable prior to the attainment of the limiting age for a child's coverage under this plan; and
(4) is financially dependent upon me for _____% of their support and maintenance (not including government assistance).

With respect to this child, I am requesting the continuance of the dependent's coverage clause which would otherwise terminate on the date of this individual becoming ineligible under my group plan because of age.

I understand that the company reserves the right to examine my child, at its own expense, and if this continuance of coverage is approved, such coverage for this child would terminate as of the date of recovery, or if any of the above four conditions are no longer satisfied.

The above named child has been covered as an eligible dependent since: Date:

I hereby authorize any physician, hospital, pharmacy, insurance company, employer, or organization to release any information regarding medical history, treatment, or disability to Allied Benefit Systems, Inc. for the purpose of validating and determining coverage available in connection with this application. Data without personal identification may be extracted for use in statistical studies.

New form or update may be required every five (5) years.

Signature of Employee	Social Security Number:	Date:
Signature of Employer		Date:

MAIL TO OHIO HEALTH PLAN
2080 CITYGATE DR.
COLUMBUS, OHIO 43219

(4/3/2020)

Attending Physician's Statement of Disability

Name of Patient:		Address:	
City:	State:	Zip Code:	Date of Birth:

History

• When did symptoms first appear or accident happen?	Month:	Day:	Year:
• Date patient ceased work because of disability. (if applicable)	Month:	Day:	Year:
• Had patient ever had same or similar condition? If yes, state when and describe. _____ Yes _____ No	Date:	Description:	

Present Condition

• Did this incapacity exist prior to the dependent's 19th birthday? _____ Yes _____ No

• Subjective symptoms:	Describe:
• Objective symptoms: (include results of EKG's, current X-rays, or any other special tests)	Describe:

• Is the patient: _____ Ambulatory _____ Bed Confined _____ House Confined _____ Hospital Confined

Diagnosis:

Treatment

• Date of first visit	Month:	Day:	Year:
• Date of last visit	Month:	Day:	Year:
• Frequency of visits:	Weekly:	Monthly:	Other:
• When did you last examine this patient:	Month:	Day:	Year:
• Degree of psychiatric impairment:	_____ None	_____ Mild	_____ Severe
• Degree of physical impairment:	_____ None	_____ Mild	_____ Severe
• Is this patient capable of holding self-sustaining employment at this time? If yes, please comment: _____ Yes _____ No	Comment:		

Name of Hospital(s)

• Please name hospital(s), if ever admitted as an in-patient:	Admission Date(s):	Discharge Date(s):

Progress

_____ Recovered _____ Improved _____ Unimproved _____ Retrogressed

Attending Physician Information & Signature

Signature: (Attending Physician)		Degree:
Social Security or Tax I.D. Number:		Date:
Street Address:		
City or Town:	State:	Zip Code: