Dear Insured:

We have received the request for your dependent's handicapped dependent coverage.

Please note that in order for a dependent to apply for handicapped dependent coverage, he or she must meet one of the following conditions:

- became mentally or physically incapable of earning his/her own living prior to age 19; or
- became permanently and totally disabled and became so on or after age 19 and is under age 26.
- These dependents will only be covered until the last day of the month they turn 26.

If your dependent meets one of these two requirements, we have listed below information for you to return to the GIC so that a decision can be made on your application. If your dependent is working, please include a copy of his/her latest earnings statement.

INFORMATION FROM THE INSURED PARENT

The insured parent must complete the “Statement From Insured Parent For Handicapped Dependent Coverage” (page 1 of 2). Please answer all questions completely so that we can process your application as quickly as possible.

INFORMATION FROM THE DEPENDENT’S PERSONAL PHYSICIAN

Please have the Physician’s Statement (page 2 of 2) completed by the dependent’s personal physician; the physician must be licensed to practice medicine in Massachusetts or the state in which you reside.

Please return the entire completed application to us. We shall try to have a response to you within four to six weeks of receiving your completed application. If you have any questions concerning this application, contact us at (617) 727-2310.

Sincerely,

Group Insurance Commission
STATEMENT FROM INSURED PARENT FOR HANDICAPPED DEPENDENT COVERAGE

This form will be returned if it is not fully completed.

Full Name of Dependent ____________________________________________
Dependent’s Date of Birth ____________________ Dependent’s Soc. Sec. Number ____________________
Dependent’s Address _____________________________________________
City ___________________________ State ________ Zip Code ________________
Dependent’s Marital Status ____________________________
Full Name of Insured ________________________________________________
Insured’s Address _________________________________________________
City __________________________ State ________ Zip Code _________________
Insured’s Social Security Number ____________________________
Date Dependent Became Totally Disabled __________________________
Is your dependent working? Yes ___ No ___
   Is yes, indicate name of employer ________________________________
   Indicate annual salary _______________________________
If the dependent is over age 19, have they had health insurance coverage from age 19 to the present? 
   YES _______ No _______
   If YES, please provide the following:
   Name of Insurance Carrier ________________________________
   Name of Employer ________________________________
   The effective date of coverage ________________________________
   Is coverage still in effect? Yes _______ No _______
   If No, when was coverage cancelled and why? ________________________________
If No, please provide the following:
Is your dependent eligible for Medicare Benefits? Yes ___ No ___ Never Applied for Medicare _______
If YES, please include a photocopy of the Medicare Claim Card
If NO, please include a letter from your local Social Security Office advising of the reason the dependent is not eligible for Medicare benefits.

Please read and sign the following statement and if the dependent is capable, please also have the dependent sign.

I hereby apply for handicapped dependent coverage and agree to periodic independent physician examinations as requested by the GIC. I hereby certify under the pains and penalties of perjury that all statements I have made on this form are true. I understand that if I misrepresent or provide false or incomplete information on this form, my GIC coverage may be terminated (possibly retroactively), in addition to other legal remedies and financial consequences, at the GIC’s discretion.

Signature of Insured Parent ______________________ Date _____________________

Signature of Dependent ______________________ Date _____________________
PHYSICIAN'S STATEMENT FROM ATTENDING PHYSICIAN

Note: this form will be returned if not fully completed.

Insured Parent’s Name________________________________________________________

Name of Patient _____________________________________________________________

Patient’s diagnosis and date of illness ____________________________

(a) Is the patient currently working? YES____ NO____

(b) Is the patient currently capable of self support YES______ NO______

(c) If NO to question b is there any potential that the patient will eventually be capable of self-support?
YES____ NO____

(d) If YES to question c, please provide your best estimate of when the patient will be capable of self-support. ____________________________

Date of onset of disability (the inability to support themselves).________________________

How long have you been treating this patient for the diagnosis indicated above? State other diagnosis if necessary.

Include first and most recent visits. ____________________________________________

__________________________________________________________________________

__________________________________________________________________________

Describe your treatment plan including a prognosis and goals for this patient in as much detail as possible and, if the patient is enrolled in a vocational training, rehabilitation or similar program, include goals and timetables that have been established for the program. (Attach other sheets as necessary.)

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Under the pains and penalties of perjury, I attest that all statements I have made on this form are true.

Physician’s Signature_________________________________ Date ____________________

Physician’s Data (please print or type the following information):________________________

Name_________________________________________Specialty _________________________

Address_________________________________City_________State________ Zip Code _______

Telephone No ________________________________

Insured: Mail pages 1 and 2 together to the GIC at the address below. Keep a copy for your records.

Commonwealth of Massachusetts Group Insurance Commission
P.O. Box 556
Randolph, MA 02368

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