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 8747
Boston, MA 02114