CONTINUED DEPENDENT COVERAGE FOR A DISABLED CHILD

Please type or print. The Participant is responsible for the completion of this form without expense to USW HRA.

TO BE COMPLETED BY PARTICIPANT:

Participant's Name:	
Street Address/P.O. Box:	
City, State, Zip:	
Phone Number:	
Dependent's Name:	
Dependent's Social Security Number:	
Dependent's Date of Birth:	
Participant's Employer:	Group #:
Participant's Social Security Number:	
Participant's Statement: On my disabled child's 19th birthday, and at all times since then, he or she has been both: (1) Continuously incapable of self-sustaining employment by reason of mental or physical disability incurred prior to age 19, and (2) Unmarried.	
Participant's Signature:	Date:

TO BE COMPLETED BY PHYSICIAN:

Diagnosis: _____
_____
_____

Symptoms: _____
_____

Objective Findings: _____
_____
_____

History (*please provide a brief history and attach narrative report, physician's notes, or operative reports if available*): _____
_____
_____
_____

When did symptoms first appear? _____

Date patient first consulted you for this condition: _____

Dates of subsequent treatment (*attach statement if convenient*): _____

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Frequency of treatments: _____
Condition: __ Retrogressed __ Unimproved __ Improved __ Recovered
Physician's Name: _____ Specialty: _____
Physician's Address: _____
City, State, Zip: _____
Phone Number: _____ Fax Number: _____
Physician's Signature: _____ Date: _____

Please mail or fax the completed form to the address on this letterhead. Thank you for your cooperation.