

MEDICAL MUTUAL™ REQUEST TO EXTEND LIMITING AGE FOR DEPENDENT CHILD

To the Policyholder:

Your certificate (or benefit booklet) provides that coverage for certain Dependents may continue beyond the limiting age specified in your Schedule of Benefits. The information requested on this application allows Medical Mutual to administer this provision. The Policyholder must complete each question in Section 1, and the Dependent's Attending Physician must complete each question in Section 2. **Please return this application to Medical Mutual, Attention: Membership Department, 2060 East 9th St., Cleveland, OH 44115, Mailzone 01-6B-6200.**

SECTION 1 – TO BE COMPLETED BY POLICYHOLDER

Policyholder's Name		Certificate #	Group #	Name of Group
Dependent's Name			Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Birthday Month/Day/Year / /
Policyholder's Address (number, street, city, state & zip code)				Relationship of Dependent to Policyholder
				Does Dependent Have a Legal Guardian? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is Dependent Married? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is Dependent Mentally Retarded? Yes <input type="checkbox"/> No <input type="checkbox"/> IQ _____	Is Dependent Physically or Mentally Handicapped? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, What is the Handicap?		Date of Onset of Dependent's Condition:
Does Dependent receive SSI or Medicare? If yes, provide documentation. Yes <input type="checkbox"/> No <input type="checkbox"/>	Is Dependent Incapable of Self-Sustaining Employment? Yes <input type="checkbox"/> No <input type="checkbox"/>	Was Dependent Listed on Your Last Income Tax Return? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Do you Support the Dependent? Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes", What Part of Support Do You Contribute? (% of total)		Is Dependent Employed Now? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Was Dependent Ever Employed? Yes <input type="checkbox"/> No <input type="checkbox"/> Give Name(s) of Employer(s) _____		Type of Work Done: _____ _____ Hours Worked Per Week:		
Is Dependent Able to: Ambulate? Yes <input type="checkbox"/> No <input type="checkbox"/> Speak? Yes <input type="checkbox"/> No <input type="checkbox"/> Feed Self? Yes <input type="checkbox"/> No <input type="checkbox"/> Read? Yes <input type="checkbox"/> No <input type="checkbox"/> Write? Yes <input type="checkbox"/> No <input type="checkbox"/> Bathe self? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Can Dependent Be Left Alone? Yes <input type="checkbox"/> No <input type="checkbox"/> Who Does Dependent Live With? _____ Past Vocational Training: _____ Level of Education: _____ At What Age or Grade Level Dependent Functions: _____ years / grade level (circle one) Self Care Skills: _____ General Physical Capabilities: _____ Disabilities _____ Communication Skills: _____ Why Dependent is Unable to Work - Attach documentation of pertinent info such as school records, etc. _____ _____				
Is Dependent Covered Under Any Other Group Medical Insurance or Pre-payment Program? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Identify The Other Insurance Carrier _____ Policy Number _____ Policyholder _____				
I CERTIFY THAT INFORMATION PROVIDED ON THIS APPLICATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.				
Signature of Policyholder _____			Date _____	

MEDICAL MUTUAL™

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SECTION 2 – TO BE COMPLETED BY ATTENDING PHYSICIAN

This report requests evidence of the Disabled Dependents Status of your patient, to assist us in determining eligibility for group coverage beyond the dependent age limit.

"Disabled Dependent Status" means the incapacity to achieve self-support through employment at a minimum level because of any condition defined by contract or law as handicap.

Patient Name:	Policyholder SSN:
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When did the symptoms first appear or accident happen?	Date patient became incapacitated by handicap or retardation:	Has the patient been continuously incapacitated or retarded? Yes <input type="checkbox"/> No <input type="checkbox"/>
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Diagnosis:

Symptoms: _____ _____ _____	Objective findings (current signs, results of pertinent diagnostic studies): _____ _____ _____
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Nature of treatment (including surgery, therapy, medications, etc):

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 (50-70%)

Class 5 - Severe limitation of functional capacity: incapable of minimal (sedentary) activity. (75-100%)

Remarks:

INTELLECTUAL IMPAIRMENT:

None (IQ 85 and above)

Borderline (IQ 71-84)

Mild (IQ 50-70)

Moderate (IQ 35-49)

Severe/Profound (IQ 34 and below)

Remarks: _____

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REQUEST TO EXTEND LIMITING AGE FOR DEPENDENT CHILD

SECTION 2 – TO BE COMPLETED BY ATTENDING PHYSICIAN-CONTINUED

Patient Name:	Policyholder SSN:
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Highest level of education:	Has patient had Vocational Training? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, what type of job has the patient been trained for?
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Do you expect a marked improvement? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, when will patient recover sufficiently to become employed? _____ _____	If no improvement expected, explain: _____ _____ _____
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Is patient: Ambulatory? House confined? Nursing home confined?
 Bed confused? Hospital confined? Wheelchair confined?

Is this patient capable of self-sustaining employment? Yes No
 Please explain:

REMARKS AND SUGGESTIONS: (other medical conditions, and any other information that would enable us to make a determination of the Dependent's incapacity)

Please attach documentation of pertinent medical records if necessary.

Attending Physician's Name (print)	Attending Physician's Phone number:
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Attending Physician's Address: _____ _____ _____	_____ Attending Physician's Signature/Date
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Please return to:
 Attn: Membership Department
 Medical Mutual
 2060 East 9th Street
 Cleveland, OH 44115-1355

Mailzone 01-6B-6200

COVERAGE FOR A MENTALLY RETARDED OR PHYSICALLY HANDICAPPED DEPENDENT

Pursuant to Ohio Revised Code Section 3923.24 (effective January 1, 1972), a mentally retarded or physically handicapped child may not be terminated as a dependent under a family contract upon attaining the limiting age of the certificate provided the dependent:

- is not married
- became mentally retarded or physically handicapped before reaching the limiting age for dependent children specified in the certificate
- is incapable of self-sustaining employment by reason of mental retardation or physical handicap which commenced prior to the limiting age for dependent children specified in the certificate.
- is primarily dependent upon the policyholder for support and maintenance

AND PROVIDED THAT

Proof of such incapacity and dependency must be furnished to Medical Mutual of Ohio® within thirty-one days of the dependent's attainment of the limiting age for dependent children specified in the certificate.

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)