PARAMOUNT HEALTH CARE

APPLICATION FOR CONTINUATION OF DEPENDENT COVERAGE

The form is for a child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who has reached the limiting age for dependent children specified in the contract. Please read the instructions on reverse side of this form. Please type or print.

Section I - To Be Completed By Subscriber

Dependent Child's Name (Last, First, Initial)	Child's Sex Male _____ Female ___	Child's Birth date Mo Day Yr	Relationship to Subscriber

Subscriber's Address (Number, Street, City, State & Zip Code)

Child's Marital Status Single ___ Widowed ___ Married ___ Divorced ___	Date Child's Disability Occurred	Is Child permanently residing in Your Household? Yes ___ If "No" Explain No ___

Is Child Dependent on Employed? You For Support? Yes ___ No ___	If "Yes" What Part of Support Do You Contribute? (% of Total) _____	Was Child Taken as a Dependent On Your Last Income Tax Return? Yes ___ No ___	Was Child Ever Yes ___ No ___

Is Child Employed Now? Yes ___ No ___	If Answer to Either of the Last Two Questions is "Yes", Give Names (s), Address(es) of Employers(s) and Date(s) Employed:

Is Dependent Eligible for Any Other Care Under Federal, State or Local Law? Yes ___ No ___	If "Yes" Give Details:

Do You or Your Spouse Have Other Health Care Coverage? Yes ___ No ___	If "Yes" Give Name and Address of Insurance Company:

I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge. I hereby authorize any physician or other person who has attended my above named dependent child or who may hereafter attend or examine such child to disclose any knowledge or information thereby acquired by him/her to subscriber's health plan.

_____	_____	_____
Date	Signature of Subscriber	Soc. Sec. No. of Subscriber

Section II - To Be Completed By Attending Physician

Has Child's Disability Existed Continuously up to the Present? the Yes ___ No ___	Date Child's Disability Occurred	What is Child's IQ?	Prognosis (Estimate months or years)	Is Child Now Incapable of Self-support because of Disability? Yes ___ No ___

Nature of Disability (Please give as much detail as practicable) - Use other side of sheet if necessary.

_____	_____	
_____	Date	Signature of Physician
Physician Address		

INSTRUCTIONS

Subscriber - Please complete Section I on the other side of this form.

- Give this form to the Primary Care Physician.

- After Physician fills out section II then send the form to:

Paramount Health Care – Att: Membership Dept
P.O. Box 928
Maumee, OH 43697-0928

Or Fax to: 419-887-2016

Primary Care Physician - Please complete Section II on the other side of this form and return to the subscriber.