Disability Status Request Form Instructions

CareConnect Healthier Insurance

Your completed paperwork is required within 31 days of your dependent reaching the terminating age. Completed paperwork includes the Disability Status Request Form.

The PHYSICIAN'S/SURGEON'S STATEMENT section of the Disability Status Request Form must be signed by your dependent's doctor and accompanied by supporting documentation on the doctor's office stationary.

Supporting documentation must include:

- The specific nature of the condition
- Signs and symptoms associated with the condition
- The date such condition commenced; and
- A recent evaluation (within six months) that demonstrates how your dependent's condition prevents any form of self-sustaining employment and that accommodation is not possible
- Doctor's contact information including telephone and fax numbers—PRINTED CLEARLY.

FOR NEW ENROLLMENTS ONLY

The subscriber must provide evidence that the dependent has had continuous health plan coverage, group or individual, prior to attaining the terminating age and the coverage remains in effect. You must attach a certificate of creditable coverage or other evidence of prior coverage with this request.

Continued coverage for your dependent may be available, if he or she:

- Is not married
- Suffers from mental illness,[1] intellectual disability,[2] developmental disability,[3] or physical handicap[4]
- Had such a condition before reaching the age at which dependent coverage would otherwise end
- Is not capable of self-sustaining employment*due to the condition, and proof of this along with the completed Disability Status Request Form is sent to us within 31 days of reaching the coverage termination age.

1. **Mental Illness:** This term refers to a mental disease or mental condition that is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation. It does not include alcoholism, substance abuse and chemical dependence.
2. **Intellectual Disability:** This term refers to subaverage intellectual functioning that originates during the developmental period and is associated with impairment in adaptive behavior.
3. **Developmental Disability:** This term refers to a disability of a person that:
   a. (1) Is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia or autism;
      (2) Is attributable to any condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of an intellectually disabled person or requires treatment and services similar to those required for such person; or
      (3) Is attributable to dyslexia resulting from a disability described in subparagraph (1) or (2) of this paragraph
   b. Originates before such person attains age 22;
   c. Has continued or can be expected to continue indefinitely; and
   d. Constitutes a substantial handicap to such person's ability to function normally in society.
4. **Physical Handicap:** This term refers to a condition, function or physical disability that makes participation in certain usual activities of daily living difficult or impossible. A physical handicap may be present at birth or develop over an individual's lifespan.

*The inability to find employment or a reduction in work capability is not, in itself, evidence of eligibility. If an intellectually disabled, mentally ill, developmentally disabled, or physically handicapped dependent is working, the extent of his or her earning capacity will be evaluated. He/she must be chiefly dependent upon the subscriber for support and maintenance.

This process relates only to determinations of eligibility for health coverage beyond the terminating age for a dependent child who is incapable of self-sustaining employment due to mental illness, developmental disability, intellectual disability or a physical handicap. A finding by CareConnect that the dependent child qualifies as a dependent incapable of self-sustaining employment pursuant to the submission of a completed Disability Status Request Form does not mean that the dependent is considered disabled by CareConnect for any other purpose.

Disability Status Request Form

CareConnect Healthier Insurance

Please complete this form to request continued coverage beyond the terminating age for an adult unmarried dependent who is incapable of self-sustaining employment.

SUBSCRIBER INFORMATION

Answer all questions below. Omitted information will cause delays.

Last Name First Name Middle Name

Member ID (if applicable):

Address: Street City State Zip

Social Security #:

Sex: ☐ Male ☐ Female

Date of Birth: ____/____/____ MM DD YYYY

Phone:

DEPENDENT INFORMATION

Last Name First Name Middle Name

Address: Street City State Zip

Sex: ☐ Male ☐ Female

Date of Birth: ____/____/____ MM DD YYYY

Marital Status

☐ Married ☐ Divorced ☐ Widowed ☐ Single

Name and address of dependent's current employer (if applicable):

Is dependent eligible for care under Medicare? ☐ Yes ☐ No

Medicaid ID # (if applicable):_____

Is this dependent chiefly reliant on the subscriber for support and maintenance? ☐ Yes ☐ No

Is the dependent listed as a dependent on your last Federal Personal Income Tax return? ☐ Yes ☐ No If No, explain below.

Explanations:

Has the dependent previously been covered as a disabled dependent? ☐ Yes ☐ No

If Yes, provide: Policy provider name:_____ Dates of coverage:_____

Please provide a certificate of creditable coverage or other evidence of prior coverage along with this form.

Has the dependent been found eligible as a disabled Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) recipient?
(If yes, documentation is required to evaluate disabled dependent coverage. Example: Notice of Award letter): ☐ Yes ☐ No

Is dependent employed? ☐ Yes ☐ No If yes: ☐ FT ☐ PT If no: Date last employed:____/____/____

I certify that the statements and answers given are complete and correct to the best of my knowledge and belief. No information required to be given, either expressly or by implication, has been knowingly withheld. I am also aware that additional information may be required to make a determination of coverage and that presenting this documentation does not imply automatic coverage. I agree to promptly advise CareConnect within 30 days of any change that affects the dependent's eligibility.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

CareConnect will not be able to continue coverage for, or enroll, your dependent unless we receive, review and approve your paperwork within 31 days of your dependent reaching the terminating age. We have the right to check whether the adult dependent continues to qualify as a dependent under the terms of your CareConnect policy. A finding by CareConnect that this adult dependent qualifies as a dependent does not mean that he or she is considered disabled by CareConnect for any other purposes.

▶ Signature (Subscriber):_____ Date:____/____/____ MM DD YYYY

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PHYSICIAN'S/SURGEON'S STATEMENT

Answer all questions below. Omitted information will cause delays. (Any fee for completion of this statement is to be paid by the subscriber.)

Patient's Name:

Last Name First Name Middle Name

Patient's date of birth:

MM DD YYYY

Is this patient presently incapable of sustaining employment? ☐ Yes ☐ No

If yes, please choose one of the following conditions:

☐ Intellectual/Developmental Disability
☐ Mental Illness
☐ Physical Handicap
☐ Other (Explain)

Date dependent became incapable of self-sustaining employment:

MM DD YYYY

Please provide the diagnosis of the condition(s) causing the incapacitation and provide supporting documentation of the physical and/or functional limitations that prevent the dependent from being capable of self support. Attach any written documentation or medical records on office stationary.

Is the dependent able to work full or part time? ☐ No ☐ Yes, from date: ____/____/____

Physician's/Surgeon's Name (Print):	Phone:	Fax:

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▶ Signature:_____ Date:____/____/____

MM DD YYYY

Please return the completed form to CareConnect by:

MAIL	EMAIL	FAX
CareConnect Attention: Enrollment Department 2200 Northern Blvd., Suite 104, East Hills, NY 11548	enrollment@careconnect.com	516-405-7859

INTERNAL USE ONLY

CareConnect Medical Management:

Medical Director:_____ Date:____/____/____

Signature MM DD YYYY

CareConnect Enrollment:

Enrollment Supervisor:_____ Date:____/____/____

Signature MM DD YYYY

Disability Status Request Form

CareConnect

Please complete this form to request continued coverage beyond the terminating age for an adult unmarried dependent who is incapable of self-sustaining employment.

SUBSCRIBER INFORMATION

Answer all questions below. Omitted information will cause delays.

Last Name First Name Middle Name

Member ID (if applicable):

Address: Street City State Zip

Social Security #:

Sex: ☐ Male ☐ Female

Date of Birth: ____/____/____ MM DD YYYY

Phone:

DEPENDENT INFORMATION

Last Name First Name Middle Name

Address: Street City State Zip

Sex: ☐ Male ☐ Female

Date of Birth: ____/____/____ MM DD YYYY

Marital Status

☐ Married ☐ Divorced ☐ Widowed ☐ Single

Name and address of dependent's current employer (if applicable):

Is dependent eligible for care under Medicare? ☐ Yes ☐ No

Medicaid ID # (if applicable):_____

Is this dependent chiefly reliant on the subscriber for support and maintenance? ☐ Yes ☐ No

Is the dependent listed as a dependent on your last Federal Personal Income Tax return? ☐ Yes ☐ No If No, explain below.

Explanations:

Has the dependent previously been covered as a disabled dependent? ☐ Yes ☐ No

If Yes, provide: Policy provider name:_____ Dates of coverage:_____

Please provide a certificate of creditable coverage or other evidence of prior coverage along with this form.

Has the dependent been found eligible as a disabled Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) recipient?
(If yes, documentation is required to evaluate disabled dependent coverage. Example: Notice of Award letter): ☐ Yes ☐ No

Is dependent employed? ☐ Yes ☐ No If yes: ☐ FT ☐ PT If no: Date last employed:____/____/____

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(Continued on other side)

PHYSICIAN'S/SURGEON'S STATEMENT

Answer all questions below. Omitted information will cause delays. (Any fee for completion of this statement is to be paid by the subscriber.)

Patient's Name:

_____
Last Name First Name Middle Name

Patient's date of birth:

____/____/____
MM DD YYYY

Is this patient presently incapable of sustaining employment? ☐ Yes ☐ No
If yes, please choose one of the following conditions:

☐ Intellectual/Developmental Disability
☐ Mental Illness
☐ Physical Handicap
☐ Other (Explain)

Date dependent became incapable of self-sustaining employment:

____/____/____
MM DD YYYY

Please provide the diagnosis of the condition(s) causing the incapacitation and provide supporting documentation of the physical and/or functional limitations that prevent the dependent from being capable of self support. Attach any written documentation or medical records on office stationary.

Is the dependent able to work full or part time? ☐ No ☐ Yes, from date: ____/____/____

Physician's/Surgeon's Name (Print):	Phone:	Fax:

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▶ Signature:_____ Date:____/____/____
MM DD YYYY

Please return the completed form to CareConnect by:

MAIL	EMAIL	FAX
CareConnect Attention: Enrollment Department 2200 Northern Blvd., Suite 104, East Hills, NY 11548	enrollment@careconnect.com	516-405-7859

INTERNAL USE ONLY

CareConnect Medical Management:

Medical Director:_____ Date:____/____/____
Signature MM DD YYYY

CareConnect Enrollment:

Enrollment Supervisor:_____ Date:____/____/____
Signature MM DD YYYY