



Application for Extension of Over Aged Dependent Child Coverage

PART I – TO BE COMPLETED BY THE SUBSCRIBER OR GUARDIAN

Please complete all sections. Initial extension of coverage, if granted, is for a minimum of two years. After initial extension, it is necessary to submit a physician's statement for a disabled dependent child annually unless otherwise requested.

A. SUBSCRIBER INFORMATION

Subscriber's Name _____ Subscriber ID# _____ Date of Birth _____
(LOCATED ON ID CARD)

Address _____ Unit/Apt.# _____

City _____ State _____ ZIP _____ Ph# (____) _____

Employer _____

B. DEPENDENT INFORMATION

LAST NAME	FIRST NAME	INITIAL	SEX	RELATIONSHIP	DATE OF BIRTH DD/MM/YY	LEGALLY MARRIED Y/N

1. Does the dependent reside in your home? Yes No
2. If the dependent does not reside in your home, does he/she live independently? Yes No
 Dependent's Address (if different from Subscriber's) _____
3. What is the nature of the dependent's mental or physical incapacity? _____

4. When did the illness or injury begin? _____
5. Has the dependent been continuously incapable of self-support since that date? Yes No
 If no, please explain _____

6. Has the dependent received a vocational assessment from the State Rehabilitation Service? Yes No
 If yes, please submit a copy
7. Has the dependent ever been able to do full or part-time work of any kind since the illness or injury began? Yes No
 If yes, from what date? _____
 What types of work has the dependent performed? _____
 Dependent's current employment status Not employed Employed part-time Employed full-time
8. Is the dependent claimed as your dependent for federal and state income tax purposes, or is he/she dependent on you for more than one-half of his or her support as defined by the Internal Revenue Code of the United States? Yes No
 If yes, has the IRS or State confirmed dependency of the child? Yes No
 If yes, when was the dependency status reviewed? _____
9. The dependent is receiving an estimated total income of \$ per month from all sources other than me.
 Source(s) of income _____
10. Has the dependent been continuously enrolled with no break of more than 63 days under any form of health care coverage since his or her 26th birthday? Yes No
11. Did the dependent become disabled before reaching age 26? Yes No

C. SIGNATURE

I CERTIFY THAT THIS INFORMATION FURNISHED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. IF THESE CIRCUMSTANCES SHOULD CHANGE IN ANY WAY, I WILL INFORM MY EMPLOYER OR SELECTHELATH.

Subscriber or Guardian Signature _____ Date _____

Dependent Signature _____ Date _____

Please mail completed application to:
 SelectHealth
 Attn: Enrollment Department
 5381 Green Street
 Murray, UT 84123

PART II — TO BE COMPLETED BY THE DEPENDENT’S PHYSICIAN

Please complete the statement in reference to the dependent named in Part I of this form.

A. MEDICAL QUESTIONNAIRE

Patient’s Name _____ Date of Birth _____

1. Diagnosis _____

2. When did present illness begin or injury occur? _____

3. Treatment _____

4. Please provide a statement describing the patient’s functional capacity _____

5. Degree of disability

Is this patient able to do full or part-time work of any kind? Yes No If yes, what type? _____
If not, when do you think the patient may be able to do some work of any kind? _____
Is the patient capable of self-support? Yes No

6. The patient is presently Ambulatory Hospital-confined House-confined Bed-confined

7. Progress Recovered Improved Unimproved Retrogressed

8. Prognosis _____

9. Remarks _____

B. PHYSICIAN SIGNATURE

Physician’s Name (Print) _____ Ph# (_____) _____

Address _____

City _____ State _____ ZIP _____

Signature _____ Date _____