MEDICAL MUTUAL®

Please return form to
Attn: Membership Department
Medical Mutual
100 American Road
Cleveland, OH 44144

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, 100 American Road, Cleveland, OH 44144.**

SECTION 1 – TO BE COMPLETED BY POLICYHOLDER

Policyholder's Name	Certificate #	Group #	Name of Group

Dependent's Name	Sex Male ☐ Female ☐	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 ☐ No ☐

Is Dependent Married? Yes ☐ No ☐	Is Dependent Mentally Disabled? Yes ☐ No ☐ **IQ** _____	Is Dependent Physically or Mentally Disabled? Yes ☐ No ☐ If Yes, What is the disability?	Date of Onset of Dependent's Condition:

Does Dependent receive SSI or Medicare? **If yes, provide documentation.** Yes ☐ No ☐	Is Dependent Incapable of Self-Sustaining Employment? Yes ☐ No ☐	Was Dependent Listed on Your Last Income Tax Return? Yes ☐ No ☐

Do you Support the Dependent? Yes ☐ No ☐	If "Yes", What Part of Support Do You Contribute? (% of total)	Is Dependent Employed Now? Yes ☐ No ☐

Was Dependent Ever Employed? Yes ☐ No ☐
Give Name(s) of Employer(s)
_____
_____

Type of Work Done:
_____
_____
_____
Hours Worked Per Week:

Is Dependent Able to: Ambulate? Yes ☐ No ☐ Speak? Yes ☐ No ☐ Feed Self? Yes ☐ No ☐
Read? Yes ☐ No ☐ Write? Yes ☐ No ☐ Bathe self? Yes ☐ No ☐

Can Dependent Be Left Alone? Yes ☐ No ☐ 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 ☐ No ☐ 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

For an explanation of the law, see the reverse side of the form.

MEDICAL MUTUAL REQUEST TO EXTEND LIMITING AGE FOR DEPENDENT CHILD

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:

When did the symptoms first appear or accident happen?	Date patient became incapacitated by disability.	Has the patient been continuously incapacitated or mentally disabled? Yes ☐ No ☐

Diagnosis:

Symptoms:	Objective findings (current signs, results of pertinent diagnostic studies):
_____	_____
_____	_____
_____	_____
_____	_____

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:

_____

_____

_____

_____

MEDICAL MUTUAL REQUEST TO EXTEND LIMITING AGE FOR DEPENDENT CHILD

SECTION 2 – TO BE COMPLETED BY ATTENDING PHYSICIAN-CONTINUED

Patient Name:	Policyholder SSN:

Highest level of education:	Has patient had Vocational Training? Yes ☐ No ☐	If yes, what type of job has the patient been trained for?
Do you expect a marked improvement? Yes ☐ No ☐	If yes, when will patient recover sufficiently to become employed? _____ _____	If no improvement expected, explain: _____ _____ _____

Is patient: ☐ Ambulatory? ☐ House confined? ☐ Nursing home confined?
☐ Bed confined? ☐ 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:
Attending Physician's Address: _____ _____ _____ _____	_____ Attending Physician's Signature/Date

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COVERAGE FOR A MENTALLY DISABLED OR PHYSICALLY DISABLED DEPENDENT

A mentally disabled or physically disabled 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 disabled or physically disabled before reaching the limiting age for dependent children specified in the certificate

– is incapable of self-sustaining employment by reason of mental disability or physical disability 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 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.