



# First Administrators, Inc.

## Application to Continue Handicapped Child

This form should be completed by the Member to apply for continued coverage beyond the maximum age defined in the policy for the Dependent (other than spouse) named below. Except for age, the Dependent must continue to be a Dependent as defined in the policy. This Dependent must be incapable of self-support as the result of a Developmental Disability or Physical Handicap and must be dependent on the Member for primary support.

Account Number

### A. Employee Information

Your name (last, first, middle initial)		Date of birth (mo/day/yr)	Social security number
Home address (street)	City	State	Zip Code
			Home phone number ( )

### B. Dependent Information

Dependent's name (last, first, middle initial)		Date of birth (mo/day/yr)	Social security number
Was Dependent covered by prior carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date prior coverage ended / /	Name and phone number of prior carrier

### C. Details About Incapacity: Give complete details so processing is not delayed.

Description of incapacity	How does incapacity interfere with daily life?
When did incapacity start?	

### D. Schools and Jobs

<p>1. Has this Dependent been going to a school or training facility since reaching age 19 or age shown in policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, has this Dependent been going full-time? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. List schools and Facilities attended: _____ Is this a custodial care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates attended: From _____ To _____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. What education level has been reached?</p> <p>4. How was this level reached? <input type="checkbox"/> Special Education Program <input type="checkbox"/> Regular classes</p> <p>5. Has this Dependent been working? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, proceed to question #10.</p> <p>6. If so, where and for how long?</p>	<p>7. How many hours per week does this Dependent work?</p> <p>8. Wage earned \$ _____</p> <p>9. Describe the job duties: _____</p> <p>10. If this Dependent has not been working, has job placement been suggested? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not? _____ If yes, what type of placement? _____</p> <p>10. What is it about the incapacity that prevents employment? _____</p> <p>11. What is it about the capacity that prevents employment? _____</p> <p>12. Please provide reason for incapacity. _____</p>
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### E. Daily Activities

<p>1. Can this dependent drive a car on his/her own? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Does this Dependent need help in daily travel to School and/or work? <input type="checkbox"/> Yes <input type="checkbox"/> No activities outside the house? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Does this Dependent live at home? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, where does this Dependent live? _____</p> <p>4. If this Dependent's incapacity requires residence at any place other than the home address shown on this form give name and address of such place and the amount of time spent there. Name of residence _____ Amount of time spent there _____</p>	<p>5. Do you regularly provide more than one-half of the financial support of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain: _____</p> <p>6. Is this Dependent claimed as a Dependent by you for Federal income tax purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain: _____</p> <p>7. Does this Dependent manage his/her own money? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Does this Dependent have a checking account? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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### F. Member Signature

I represent that to the best of my knowledge and belief all statements and answers made by me on this form are true, complete and correct. They shall be a part of this application for continued coverage under the described group policy. I agree that the coverage is subject to approval by First Administrators, Inc. at its home office in Sioux City, Iowa; and that continued coverage is subject to written request being made within 31 days after the date the Dependent reaches the maximum age defined in the policy.

I authorize any doctor, health care provider, hospital, clinic, or other medically related facility who has knowledge of the Dependent to give to First Administrators, Inc. any such information. I also understand that any charge for this information is to be paid by me.

Member's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

**G. Statement of Physician About Dependent Named on Reverse Side: This section must be completed by the physician.**

Date you first attended this patient \_\_\_\_\_

Are you presently seeing this patient for incapacity? \_\_\_\_\_

Please furnish the history of the incapacity. Include diagnosis, treatment, results of special studies, present course, prognosis, etc. If the space below does not allow room for sufficient history, please attach the history to this form.

In your opinion, is this patient capable of self-support?     Yes     No

If no: What is it about the incapacity that prevents self-support? \_\_\_\_\_

How long has the incapacity existed? \_\_\_\_\_

How long may such incapacity be expected to continue? \_\_\_\_\_

Is self-support possible in the future? \_\_\_\_\_

If so, when? \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date signed \_\_\_\_\_

Physician's printed name \_\_\_\_\_

Address (street) \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

Phone Number: \_\_\_\_\_