# Request for Continuation of Medical Coverage
# For Totally and Permanently Disabled Dependent

For USC Trojan Care EPO, USC EPO Plus or USC PPO Plan Members

Your plan requires verification of continued total and permanent disability periodically to maintain continued eligibility. Please complete the “Request for Continuation of Medical Coverage for Totally and Permanently Disabled Dependent” form and have your overage dependent child’s physician complete the “Totally and Permanently Disabled Dependent - Attending Physician’s Statement” form with all the necessary information required by that form.

Please return the enclosed forms by:

| Mail to: | Fax to: | Email to: |
|---|---|---|
| HealthComp | | HC-EligibilityRequest@healthcomp.com |
| Attn: Eligibility | 559-499-2464 | Attn: Eligibility |
| PO Box 45018 | Attn: Eligibility | |
| Fresno, CA 93718 | | |

If you have any questions, please do not hesitate to contact us at (855) 727-5267.

Sincerely,

HealthComp Administrators
Eligibility Department

Enclosure

HealthComp

# Request For Continuation of Medical Coverage For Totally and Permanently Disabled Dependent

| Employee Name | Subscriber Plan Identification Number | Group Number |
|---|---|---|
| Employee Address | | |
| Dependent Name | Dependent Social Security Number | Dependent Date of Birth |
| Dependent Address if different from Employee | Dependent's Marital Status | |

Has Dependent been deemed disabled by the Social Security Administration or any other governmental agency? ☐ Yes ☐ No If Yes, effective date _____

Is Dependent currently enrolled in Medicare or Medi-Cal? ☐ Yes ☐ No If Yes, effective date _____
Circle all that apply: Medicare A B D Medi-Cal

I certify under penalty of perjury that the information provided on this application is correct to the best of my knowledge and authorize release of any information requested with respect to the certification of total and permanent disability status for my dependent.

_____ _____
Employee Signature Date

Under the Plan, disabled dependents who are age 26 or older may be eligible for coverage if they qualify as your disabled dependent child. A disabled dependent child is someone who is 26 years of age or older who is totally and permanently disabled and incapable of self-support. At time of enrollment, you must submit proof of disabled status from a Physician who will certify the dependent child's total and permanent disability and incapacity for self-support. If the dependent child is currently enrolled in the Plan and then reaches the limiting age of 26, you must submit proof of disabled status 30 days before their 26th birthday in order to continue coverage. Otherwise, the dependent child will be terminated at the end of the month of their 26th birthday. The Plan will require proof of continued disabled status from time to time.

The employee must submit a completed ***Totally and Permanently Disabled Dependent Attending Physician's Statement*** (copy attached), with the above information to establish coverage beyond the plan's limiting age.

Continuation of dependent coverage will cease on the first to occur:

- Cessation of the qualifying disability;
- Failure to give adequate proof that the qualifying disability continues; or
- Termination of your dependent child coverage for reason other than reaching the maximum age.

You will be notified of the denial or approval of this request. HealthComp reserves the right to request future reviews and documentation for disabled dependents.

Please note: Any person who, with intent to defraud or knowing that he/she 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.

# HealthComp Totally and Permanently Disabled Dependent Attending Physician's Statement

**Employee Instructions**
▪ Complete Sections 1-3

**Attending Physician Instructions:**
▪ Complete Sections 4-6 and return the completed form to employee.

| | | |
|---|---|---|
| **1. Employee Information** | Employee Name | Group Number |
| **2. Employee Information** | Employee Address | Subscriber Plan Identification Number |
| **3. Dependent Child Information** | Dependent Name | Date of Birth |
| **4. Physician's Statement** If there is not enough room please attach a history to this form. | A. Diagnosis—please Include the basis of the diagnosis (e.g. tests, X-rays, physical examination, vocational tests, objective findings, etc) | |
| | B. When did disability start? | |
| | C. Date you first attended dependent | D. Last date patient was seen |
| | E. Degree of incapacity—If "total", give the explanation as to why. | |
| | F. How long has the mental or physical incapacity existed? | |
| | G. How long is this incapacity expected to continue? If it is "permanent", please give the explanation as to why. | |
| | H. Treatment | |
| | I. Results of special studies | |
| | J. Current condition- Also describe your understanding of the dependent child's current daily activities (e.g., attending school, recreational activities, social activities, average hours of daily sleep, etc) | |
| | K. Prognosis | |
| | L. In your opinion, is the dependent permanently incapable of self-support? ☐ Yes- Please Explain ☐ No | |
| | M. Is this dependent permanently unable to perform any type of work? ☐ Yes (Please explain and specify what reasonable accommodations or support would enable the dependent to work) ☐ No | |
| **5. Other Treating Physicians** | Please list the name/address and telephone number of all the physicians or other health care providers you are aware of that are currently treating this dependent for his or her mental/physical incapacity or have so treated this dependent in the last 36 months | |
| **6. Attending Physician Information** | Attending Physician's Name & Address (include street, city, state & zip code) | |
| | Attending Physician's Signature | Date |
| **7. Misrepresentation** | 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 or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Attention California Residents:** For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison, and substantial civil penalties. Many other states have similar laws. **Attention Colorado Residents:** An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division. **Attention DC Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Attention Florida and Virginia Residents:** Any person who knowingly and with intent to defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Pennsylvania Residents:** 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 or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. | |