



**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:  
HealthComp  
Attn: Eligibility  
PO Box 45018  
Fresno, CA 93718

Fax to:  
559-499-2464  
Attn: Eligibility

Email to:  
[HC-EligibilityRequest@healthcomp.com](mailto:HC-EligibilityRequest@healthcomp.com)  
Attn: Eligibility

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

Sincerely,

HealthComp Administrators  
Eligibility Department

Enclosure



## 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, effective date _____		
Is Dependent currently enrolled in Medicare or Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> 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 26<sup>th</sup> birthday in order to continue coverage. Otherwise, the dependent child will be terminated at the end of the month of their 26<sup>th</sup> 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.



# Handicapped or 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.

<b>1. Employer Information</b>	Employer Name	Group Number
<b>2. Employee Information</b>	Employee Name	HealthComp Identification Number
<b>3. Dependent Child Information</b>	Name	Date of Birth
<b>4. Physician's Statement</b> If there is not enough room please attach a history to this form.	A. Diagnosis	
	B. When did disability start?	
	C. Date you first attended dependent	D. Last date patient was seen
	E. Degree of incapacity	
	F. How long has the mental or physical incapacity existed?	
	G. How long is this incapacity expected to continue?	
	H. Treatment	
	I. Results of special studies	
	J. Current condition	
	K. Prognosis	
	L. In your opinion, is the dependent capable of self support? <input type="checkbox"/> Yes <input type="checkbox"/> No   Please explain.	
M. Can this dependent perform any type of work? <input type="checkbox"/> Yes <input type="checkbox"/> No   Please explain		
<b>5. Other Treating Physicians</b>	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	
<b>6. Attending Physician Information</b>	Attending Physician's Name & Address (include street, city, state & zip code)	
	Attending Physician's Signature	Date
<b>7. Misrepresentation</b>	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. <b>Attention California Residents:</b> 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. <b>Attention Colorado Residents:</b> 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. <b>Attention DC Residents:</b> 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. <b>Attention Florida and Virginia Residents:</b> 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. <b>Attention Pennsylvania Residents:</b> 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.	