



**STATE EMPLOYEE HEALTH PLAN (SEHP)
APPLICATION FOR COVERAGE OF
PERMANENT AND TOTALLY DISABLED DEPENDENT CHILD**

I. The following questions are to be completed by the SEHP member:

Member's Name (LAST, FIRST, MI)	Employee ID or Social Security Number
Dependent Child's Name and Address	Social Security Number
Is the dependent child employed? If yes, please list the name and address of their employer:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the dependent child eligible for health insurance coverage through their employer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has continuous group health insurance coverage been maintained on this dependent child? If yes, please submit supporting documentation if the dependent child was previously covered under a group plan other than the SEHP.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the dependent child married?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you provide more than 50% support and maintenance for this dependent child?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the dependent child a beneficiary under Medicare?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the dependent child receiving SSI disability benefits? Note: If the dependent child is either a beneficiary under Medicare or receiving SSA disability benefits, please submit supporting documentation.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Name and Address of Dependent Child's Physician	
Name of other members of the Dependent Child's health care team (rehabilitation or mental health care specialists):	

Authorization: I hereby certify that the above listed information is true and correct.

Signature of Member	Date
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The member's signature must be notarized.

Subscribed and sworn to before me this ____ day of _____ 20____

____ My commission expires _____

Notary Public
(SEAL)

