



**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__

Notary Public
(SEAL)

My commission expires _____



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II: The following questions are to be completed by the Dependent Child's attending physician:

Dependent Child's Name (LAST, FIRST, MI)	Dependent Child's Date of Birth
Diagnosis or condition causing the Dependent Child's disability including degree of severity (use additional sheet if necessary) _____ _____ _____	
Date of onset of Dependent Child's diagnosis or condition	Date of Dependent Child's last treatment
Prognosis - estimate future duration of the Dependent Child's condition (use additional sheet if necessary) _____ _____ _____	
Is the Dependent Child capable of gainful employment, to be financially self-supporting? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is the Dependent Child now confined in an institution? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list the name and address of the institution. _____	
Physician's Name (Please print)	Physician's Address
Physician's Signature	Date