Kansas Department of Health and Environment
Division of Health Care Finance

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 ☐ No ☐
Is the dependent child eligible for health insurance coverage through their employer?	Yes ☐ No ☐
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 ☐ No ☐
Is the dependent child married?	Yes ☐ No ☐
Do you provide more than 50% support and maintenance for this dependent child?	Yes ☐ No ☐
Is the dependent child a beneficiary under Medicare?	Yes ☐ No ☐
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 ☐ No ☐
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**

The member's signature must be notarized.

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

_____ My commission expires _____

Notary Public

(SEAL)

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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 ☐ No ☐	
Is the Dependent Child now confined in an institution? Yes ☐ No ☐ If yes, please list the name and address of the institution. _____	
Physician's Name (Please print)	**Physician's Address**
Physician's Signature	**Date**