REQUEST FOR CONTINUANCE OF ENROLLMENT FOR A DISABLED DEPENDENT

PART 1 – TO BE COMPLETED BY SUBSCRIBER

Subscriber's Name	Social Security Number	Employer

Address Street City State Zip

Dependent's Name	Dependent's Birthdate	Is your son/daughter dependent on parent(s) for more than one-half his/her support?	Date on which dependent became disabled -
		__ YES __ NO	

Is the dependent Employed for Wages? __ YES __ NO If yes, please give name and address of employer

Is the dependent confined to An institution or attending School? __ YES __ NO If yes please list name of institution or school and date of admission

I UNDERSTAND AND AGREE that continuation of enrollment for the dependent named above, if approved, will remain in effect only as long as the disabled and dependency exists and so long as QualCare provides coverage for such dependent in my name, if any, remains in effect. I FURTHER UNDERSTAND AND AGREE that such plan shall have the right to request recertification as to the eligibility for continued extension of this dependent's coverage periodically as required by the plan guidelines. I represent that to the best of my knowledge all the information given above is correct, that this dependent meets the eligibility requirement of unmarried status and enrollment under my coverage.

_____ _____
Subscriber's Signature Date

PART II - TO BE COMPLETED BY DEPENDENT'S ATTENDING PHYSICIAN

I hereby certify the accuracy of the following information regarding the disability of the above named dependent:

1. Diagnosis: _____

2. ICD=9 Code: _____
_____

3. If mentally challenged, results of phychometric and/or adaptive evaluation:

Test Name _____ Mental Age _____ IQ _____

Other Comments _____

4. If physically disabled, description of disability: _____

5. To the best of your knowledge, length of time this disabilty has existed: _____

6. Prognosis concerning this disability: _____

7. In your professional opinion, is this dependent capable of engaging in self supporting employment

Currently __ YES __ NO In the future __ YES __ NO

I hereby certify that I am a practicing physician duly licensed in the State of _____

_____ _____ _____
Physician's Name (Please Print) Signature Date

Physician's Mailing Address

Please return form to: QualCare, Inc., Attn: Eligibility Department
30 Knightsbridge Road, Piscataway, NJ 0885