BEST Life
BEST Life and Health Insurance Company

REQUEST FOR CONTINUATION OF COVERAGE FOR DISABLED DEPENDENT CHILD

IF AN EMPLOYEE OR MEMBER HAS A DISABLED CHILD WHO, UNDER THE TERMS OF THE PLAN, QUALIFIES FOR COVERAGE AFTER THE POLICY LIMITING AGE, THIS FORM MUST BE COMPLETED AND SUBMITTED TO BEST LIFE WITHIN 31 DAYS FOLLOWING THE ATTAINMENT OF THE LIMITING AGE.

PART I
(TO BE COMPLETED BY THE EMPLOYEE)

Name of Employee (print last, first, middle initial) ____________________

Address (number, street, city, state and zip code) ____________________

1) Employee Social Security Number ____________________

2) Full Name of Child ____________________ Relationship (to employee) ____________________

3) Child's Date of Birth ____________________

4) Are you a new employee? Yes ☐ No ☐

If yes, was child previously covered as a disabled dependent under former employer? Yes ☐ No ☐

Effective date of coverage: ____________________ Termination date of coverage: ____________________

5) Did such disability exist prior to child's attainment of limiting age under the group plan? Yes ☐ No ☐

6) Child's Marital Status: Single ☐ Widowed ☐ Married ☐ Divorced ☐

7) Is child dependent upon you for support? Yes ☐ No ☐

If yes, what part of support do you contribute? ____________________

____

____

8) Was child ever employed? Yes ☐ No ☐

9) Is child employed now? Yes ☐ No ☐ If so, Full or Part time? ____________________

10) If yes to either question 8 or 9, give name(s) and address(es) of employer(s) and dates employed: ____________________

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11) Summary of Any Institutional Care:

Names of Institutions: ____________________

____

Dates: ____________________

Nature of Care: ____________________

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I hereby declare that all statements and answers to the above questions are complete and true.

Signature of Employee ____________________ Date ____________________

(continued on other side)

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PART II
(TO BE COMPLETED BY THE PHYSICIAN)

NOTE: The applicant is responsible for the completion of this form without expense to BEST Life.

Is child now incapable of self-sustaining employment because of Mental or Physical Disability? Yes ☐ No ☐

May child be employable in future? Yes ☐ No ☐ Questionable ☐

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Date of Onset: ____

Prognosis: ____

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Please Indicate Results of Any Intelligence Tests: ____

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Name of Physician (type or print) Physician's Signature Degree

____

Address (number, street, city, state, and zip code)

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PART III
(TO BE COMPLETED BY THE BENEFITS REPRESENTATIVE)

Policyholder Name ______________________________ Group Policy No.______________________________

Address ____

____

Date Your Company Became Covered with BEST Life: ____

Coverage Effective Date of the Employee: ____

Has this Dependent's coverage been continuously in effect prior to reaching the limiting age? Yes ☐ No ☐

If this Dependent has not applied within the 31 days following the attainment of the limiting age, please explain in full details:

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Benefits Representative ______________________________ Phone No. ______________________________

Title ______________________________ Date ______________________________