TEAMSTERS HEALTH AND WELFARE FUND
2500 McCLELLAN AVENUE, SUITE 140
PENNSAUKEN, NJ 08109
PHONE NO.# 856-382-2400 · FAX NO. #856-382-2402

APPLICATION FOR HANDICAPPED COVERAGE

IMPORTANT: READ INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS PRIOR TO COMPLETING ATTACHED FORM

INSTRUCTIONS TO SUBSCRIBER

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information", as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual 's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1. Read the ELIGIBILITY REQUIREMENTS below.
2. Provide the information requested in boxes 1 through 27 of PART I.
3. Read the conditions contained in PART 1, sign and date where indicated.
4. Forward the form to the dependent's attending Practitioner TOGETHER with the enclosed return envelope.

INSTRUCTIONS TO THE PRACTITIONER

1. Provide all information requested in PART II (on reverse side of application).
2. Forward the completed form to:

Teamsters Health & Welfare Fund
ATTN: Member Services Department
2500 McClellan Avenue, Suite 140
Pennsauken, NJ 08108

CONDITIONS NECESSARY TO ESTABLISH ELIGIBILITY

1. The dependent is unmarried.
2. The incapacitating condition started before the age specified policy age limit.
3. The dependent must have been insured before the age limit of the policy. If insured by another carrier before applying to Teamsters Health & Welfare Fund, documentation should be provided.
4. The application for continuation of enrollment must be filed within 31 days from the date the dependent reaches policy age limit.
5. The subscriber must provide proof of the dependent's incapacitation by submitting responses to the following questions at the time of application for continuation of enrollment.
6. Frequency for reassessment of continuation determined by dependent's condition and contract requirements.

PART I – TO BE COMPLETED BY SUBSCRIBER

1. SUBSCRIBER'S NAME:			2. TELEPHONE #:
3. ADDRESS:			
4. DEPENDENT'S NAME:	5. RELATIONSHIP TO SUBSCRIBER	6. DEPENDENT'S BIRTHDATE:	7. DATE OF ONSET OF DISABILITY/HANDICAP
8. NAME OF PRESENT INSURANCE CARRIER FOR DEPENDENT			9. ID#/POLICY #
10. GROUP #	11. COVERAGE START DATE		12. COVERAGE END DATE
13. PLEASE INDICATE PRIOR INSURANCE CARRIER SINCE ONSET OF DISABILITY/HANDICAP. CARRIER NAME:			14. ID#/POLICY #
15. GROUP #	16. COVERAGE START DATE:	17. COVERAGE END DATE:	*Attach any additional information on separate page*

18. WHY ARE YOU APPLYING FOR CONTINUATION OF BENEFITS FOR THE DEPENDENT AT THIS TIME?

19. CAN THE DEPENDENT PERFORM ACTIVITIES OF DAILY LIVING (e.g., bathing, dressing, eating)? □ YES □ NO
If No, please explain:

20. IS THE DEPENDENT CAPABLE OF TRAVELING TO AND FROM A DESTINATION UNATTENDED? □ YES □ NO	21. DOES THE DEPENDENT WORK FOR WAGES? □ YES If Yes, give name of employer
22. IS DEPENDENT ELIGIBLE FOR HEALTH COVERAGE THROUGH HIS/HER EMPLOYER? □ YES □ NO	□ NO If No, give reason why unable to work

23. IS DEPENDENT IN COLLEGE/SPECIAL SCHOOL OR CONFINED TO AN INSTITUTION? □ YES □ NO
If Yes, give name/location: Type of program or course of study:

24. DOES THE DEPENDENT RECEIVE OR HAS THE DEPENDENT EVER RECEIVED VOCATIONAL TRAINING DESIGNED TO INCREASE INDIVIDUAL FUNCTIONALITY?
If so, Name: If not, why not:
Dates:

25. WHAT ARE THE SPECIFIC WAYS IN WHICH YOU SUPPORT OR MAINTAIN THE DEPENDENT:

26. HOW/WHAT TYPE OF CARE DO YOU PROVIDE FOR THE DEPENDENT?

27. HAS THE DEPENDENT APPLIED FOR SSI/MEDICARE/MEDICAID? (circle all applicable)
If not, why?

In accordance with amendments to the New Jersey laws governing health service corporations whereby the enrollment of mentally impaired and/or physically disabled children who attained termination age on and after August 10, 1966 may, under certain conditions, be continued under their parent's Teamsters Health & Welfare Fund coverage beyond such termination age, I herewith request such continuation of enrollment on behalf of my child named above.

I UNDERSTAND AND AGREE that continuation of enrollment for the child named above, if approved, may remain in effect only as long as the mental impairment and/or physical disability and dependency exist, and so long as Teamster Health & Welfare Fund coverage, in my name or in the name of my spouse, if any, remains in force, with no greater than thirty days lapse between any changes in coverage, and provided that coverage is at all times of the type which includes such child. I FURTHER UNDERSTAND AND AGREE that the Plan shall have the right to require periodic recertification as to eligibility for continued extension of dependency coverage.

I represent that to the best of my knowledge and belief the information given above is correct, that the child named above meets the eligibility requirements as to unmarried status and enrollment under my coverage, and is dependent upon me for more than one-half of his/her support and maintenance.

Subscriber's Name: _____ ***Date***: _____

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

Questions to be answered by the dependent's Attending Practitioner:
(*If disability is due to mental or psychiatric disorder, please have the appropriate behavioral health provider complete form.)*

1. Specific diagnosis(s) (Use ICD9 or DSMS codes as applicable.) _____

2. If mentally impaired, define mental impairment in terms of mental age _____ IQ _____ or functional capacity in work, educational or social setting. *Please attach results or summary of most recent testing done to define dependent's functional level.*

3. If physically impaired, define physical impairment in terms of capacity to perform activities normally done by individuals of comparable age, intellectual capacity.

4. Is the condition temporary or permanent? _____ Is the condition static or progressive? _____

5. Is the condition currently controlled with medical management?

   If No, why not _____ _____ _____

   If yes, specify therapy _____

6. If dependent is attending college; working; or in a training program; what makes this individual more reliant on parental support and maintenance than his/her non-disabled peers and thus make continuation of enrollment under parent's policy necessary.

   _____

7. In your opinion, is the dependent able to work, attend school or a vocational training program? Now: □ YES □ NO
   In the Future: □ YES □ NO

   If no, why not?

I hereby certify that I am a practicing _____ duly licensed in the State of _____ and certify to the correctness of the information provided above.

Please print the following information	PRACTITIONER'S NAME
	PRACTITIONER'S ADDRESS

SIGNATURE OF PRACTITIONER	**PHONE #**	**DATE SIGNED**

PART III – TO BE COMPLETED BY PLAN

Continuation of enrollment of the dependent named above under his/her parent's coverage (is) (is not) approved. This certification applies to all coverages.

Authorized Signature: _____ ***Date***: _____