



**Application for Continuation of Insurance Due to Incapacity
 Subscriber's Statement**

The undersigned insured applies to the state & public school subscriber's insurance plan for continuation of insurance beyond the termination age specified in the policy for the child named below. This child otherwise qualifies as a dependent as defined in the policy, but is incapable of self-sustaining employment by reason of mental or physical handicap.

Section A: To be completed by the subscriber

Name of Insured Subscriber: _____ Member #: _____

Date effective under this insurance: _____ Was dependent covered at that time? Yes No

If not, when was dependent coverage effective? _____

Name of child: _____ Date of Birth: _____

Incapacity due to: mental handicap physical handicap other (please explain): _____

How long has the child been incapacitated? _____ Was this due to an injury or accident? _____

If due to an injury or accident, when and how did it occur? _____

Was child ever employed? Yes No Is child employed now? Yes No

If answer to either question is yes, give names and address of employers, dates employed and description of job duties: _____

Is child dependent upon you for support? Yes No

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

Is child covered under any other group plan (including Medicare or Medicaid)? Yes No

If yes, give name of insured: _____ Policy #: _____

Name and address of insurance company: _____

Effective Date: _____

I understand and agree that: (1) The information provided on this application is accurate and complete. (2) Any omissions or incorrect statements made by myself or anyone on this application may invalidate my and/or my dependent's coverage. (3) Coverage will become effective only on the date specified by the insurer, after the application has been approved by the insurer and after the first full premium has been paid. (4) My signature authorizes "coordination of benefits" under this coverage with other insurance I have that is subject to coordination. (5) I hereby authorize deductions from my earnings of any required insurance contribution. (6) That my eligibility and/or the eligibility of any covered dependents may be audited by EBD, or other designated party, at any time. (7) By signing this form, I hereby certify that all the information provided is true and correct.

Authorization to Obtain Medical Information: On behalf of myself, and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/insurer, or any of their designees, any and all records or information pertaining to medical history or services rendered to the health plan/insurer, for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purpose, including evaluation of an application or a claim. I also authorize, on behalf of the health plan/insurer, the use of a social security number for a purpose of identification.

Subscriber's Signature: _____ Date: _____



Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 683-0983 <http://www.ARBenefits.org>

Attending Physician's Statement

Section B: To be completed by the physician

The following questions should be answered with regard to the incapacity shown on page one of this application.

Date first treated patient: _____

Are you presently seeing this patient for the incapacity? _____

Please furnish us with the history of the incapacity. The statement should include diagnosis, treatment, results of special studies and present course of treatment.

In your opinion, is patient capable of self-sustaining employment? _____

If no, how long has incapacity existed? _____

How long may such incapacity be expected to continue? _____

Signature of Physician: _____ Date: _____

Address: _____

A photocopy of this authorization will be as valid as the original.

Any person who knowingly obtains health coverage when not eligible for coverage, presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines, confinement in prison, repayment for plan losses/claims, or loss of health coverage for life.

Signature of Subscriber: _____ Date: _____

Member #: _____

Address: _____

When both forms have been completed, submit them together to:

Employee Benefits Division/DFA
P O Box 15610
Little Rock, AR 72231-5610
Or fax to: 501-683-0983