



Identification Number

Dear Subscriber:

We are glad to confirm that our family contracts can cover mentally retarded or physically handicapped provided the child:

- has not married
- became mentally retarded developmentally disabled, mentally ill or physically handicapped before reaching the contract age limit for dependent children.
- is so incapacitated to be incapable of self supporting employment. (NOTE: The inability to find employment or a reduction in work capability does not constitute evidence of eligibility. If a mentally retarded or physically handicapped child is working, the extent of his earning capacity will be evaluated.)

When a mentally retarded or physically handicapped child over the contract of age is eligible as a dependent under a family membership, all the benefits of that membership apply. Of course our Hospital Service and Medical contracts do not provide benefits which are available in whole or in part under the laws of the United States of America or any State or political subdivision thereof.

Please have the form on the reverse side of this letter fully completed and returned to us so we may take the necessary action.

Sincerely,

Subscriber Service

PO Box 3509, Church Street Station, New York, NY 10008-3509
WellChoice products and services provided by WellChoice Insurance of New Jersey and WellChoice HMO of New Jersey

PLEASE READ THIS LETTER PRIOR TO FILLING OUT THE FORM ON THE REVERSE SIDE OF THIS PAGE.

REQUEST FOR COVERAGE

FOR AN UNMARRIED DEPENDENT CHILD **OVER** THE CONTRACT AGE LIMIT WHO IS MENTALLY RETARDED, DEVELOPMENTALLY DISABLED, MENTALLY ILL OR PHYSICALLY HANDICAPPED

INSTRUCTIONS

PLEASE TYPE OR PRINT

CONTRACT HOLDER — Please complete section 1 of this form.

ATTENDING PHYSICIAN — Please complete the physician's section, Section II, of the form and,

1. If the patient has been admitted, forward the form to the admitting officer of the hospital who will submit it to us with the notice of admission.
2. If the patient is not admitted and the claim is for your services only, attach this form to the "Statement of Services" form and return to WellChoice, PO Box 3509, Church Street Station, New York, NY 10008-3509.
3. If this form is solely for the purpose of determining eligibility in the event of future treatment, return to the parent or legal guardian.

HOSPITAL — Please attach the completed form to your notice of admission.

SECTION I — TO BE COMPLETED BY SUBSCRIBER										
NAME OF SUBSCRIBER			ADDRESS OF SUBSCRIBER (NO. & STREET, CITY, STATE, ZIP CODE, APT. NO.)							
HOSPITAL SERVICE CLAIM NUMBER			MEDICAL CLAIM NUMBER		MEMBER'S IDENTIFICATION NUMBER			GROUP NUMBER		
NAME OF DEPENDENT CHILD		SEX <input type="checkbox"/> M <input type="checkbox"/> F	ID NUMBER OF CHILD (IF ANY)		DEPENDENT'S DATE OF BIRTH MONTH DAY YEAR		DEPENDENT'S MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED			
WAS DEPENDENT CHILD EVER INSTITUTIONALIZED?		NO <input type="checkbox"/>	YES <input type="checkbox"/>	→ IF YES, GIVE NAME & ADDRESS OF INSTITUTION(S) AND →				PERIOD CONFINED FROM: _____ TO: _____		
IS DEPENDENT ELIGIBLE FOR CARE UNDER FEDERAL STATE, LOCAL LAW, MEDICARE?		NO <input type="checkbox"/>	YES <input type="checkbox"/>	→ IF YES, GIVE DETAILS AND ALL IDENTIFICATION NUMBERS				MEDICARE CLAIM NO. & HIB SUFFIX		
WAS, OR IS, DEPENDENT EMPLOYED FOR WAGES?		NO <input type="checkbox"/>	YES <input type="checkbox"/>	→ IF YES, GIVE NAME & ADDRESS OR CURRENT OR LAST EMPLOYER				EFFECTIVE DATE OF MEDICARE ELIGIBILITY PART A _____ PART B _____		
OCCUPATION			PERIOD OF EMPLOYMENT FROM: _____ TO: _____			DEPENDENT'S AVERAGE WEEKLY EARNING \$ _____				
SIGNATURE OF PARENT OR GUARDIAN:							DATE SIGNED			
SECTION II — TO BE COMPLETED BY PHYSICIAN										
IS DEPENDENT PRESENTLY INCAPABLE OF SELF-SUSTAINING EMPLOYMENT BY REASON OF: <input type="checkbox"/> MENTAL ILLNESS <input type="checkbox"/> MENTAL RETARDATION <input type="checkbox"/> DEVELOPMENTALLY DISABLED <input type="checkbox"/> PHYSICAL HANDICAP					IS INCAPACITY CONGENITAL? <input type="checkbox"/> NO <input type="checkbox"/> YES		DID INCAPACITY EXIST ON DEPENDENT'S 19th BIRTHDAY <input type="checkbox"/> NO <input type="checkbox"/> YES			
DIAGNOSIS:				DATE SYMPTOMS FIRST BECAME MANIFEST		DEPENDENT'S IQ:				
SCHOOL(S) ATTEND(ED) (ING):							DATE FROM: _____ TO: _____			
EDUCATIONAL STATUS:			WORK ABILITY:			WAS CONDITION THE RESULT OF AN ACCIDENT? DATE OF ACCIDENT: _____ <input type="checkbox"/> NO <input type="checkbox"/> YES				
IN YOUR OPINION, WILL THIS CHILD EVER BE CAPABLE OF SELF-SUSTAINING EMPLOYMENT? <input type="checkbox"/> NO <input type="checkbox"/> YES										
PLEASE USE THIS SPACE FOR REMARKS - PLEASE GIVE AS MUCH DETAIL AS POSSIBLE, INCLUDING FULL DETAILS OF THE CONDITION CAUSING THE DEPENDENT STATUS AND THE MOBILITY OF THE DEPENDENT.										
IF ADMITTED AS IN-PATIENT, GIVE NAME OF HOSPITAL:							DATE ADMITTED			
NAME OF ATTENDING M.D.				ADDRESS						
SIGNATURE OF ATTENDING M.D.:							DATE SIGNED			

FOR OFFICE USE ONLY

	BY	DATE	
HOLD			
APP'D			CHECK ONE <input type="checkbox"/> I <input type="checkbox"/> P
REJ'D			