

**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: \_\_\_\_\_

11) Summary of Any Institutional Care:

Names of Institutions: \_\_\_\_\_

Dates: \_\_\_\_\_

Nature of Care: \_\_\_\_\_

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

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_

*(continued on other side)*



BEST Life and Health Insurance Company

**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) \_\_\_\_\_  
\_\_\_\_\_

**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 \_\_\_\_\_