



Handicapped Dependent Application

All Questions Must Be Answered

Subscriber's Name (Last, First, M.I.)		Check if name change <input type="checkbox"/>	Social Security #	
Home Address (Street, City, State, Zip)		Check if new address <input type="checkbox"/>	Daytime Phone	
I request continuation of coverage for the dependent named below due to total disability				
Dependent's Name		Birth Date		Relationship to Subscriber
Dependent's Residence (Street, City, State, Zip)		Does Dependent have a contract? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, give Contract No.
Is dependent married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does dependent have personal income from any source? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Previously married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is dependent claimed on Subscriber's Income Tax? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
To what extent is dependent self-supporting?			Dependent's Social Security No.	
Is dependent attending school? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of school		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
Is dependent eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give Medicare Health Insurance number and effective date(s) from dependent's Medicare Health Insurance card. (You may have received this information from the Social Security Office pending issuance of the card.)			
	Health Insurance #:	Part A (Hospital)	Effective Date(s)	Part B (Medical)
<p>Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall so be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.</p>				
Subscriber Signature _____			Date _____	
To be completed by dependent's attending physician (M.D. or D.O.)				
1. Diagnosis (Please use standard nomenclature): _____				
a. If physical disability, describe physical impairments: _____				
b. If behavioral health disorder, describe limitations: * _____				
If a or b, describe treatment and rehabilitation currently being administered to dependent: _____				
c. If developmental delay, describe severity of condition: * _____				
Mental Age _____ I.Q. _____				
Describe capabilities and limitations of dependent: _____				
* Please attach copy of dependent's most recent psychological evaluation, WAIS and MMPI report.				
You must complete this area in full for the dependent				
Yes <input type="checkbox"/> No <input type="checkbox"/>	Feed Self	Yes <input type="checkbox"/> No <input type="checkbox"/>	Dress Self	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	Read	<input type="checkbox"/> <input type="checkbox"/>	Write	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	Drive Vehicle	<input type="checkbox"/> <input type="checkbox"/>	Handle Money	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	Bath Self	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	Speak	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	Transfer Self from Bed to Chair	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	Toilet Self	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	Ambulate Independently	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	Use Public Transportation	<input type="checkbox"/> <input type="checkbox"/>
2. To your knowledge, length of time this disability has existed: _____				
3. Probable future course and duration: _____				
4. Is the dependent institutionalized? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, give name of institution _____				
5. In your professional opinion, can this patient engage in self-supporting employment? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Please elaborate the reason for your answer: _____				
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PHYSICIAN SIGNATURE _____			Date _____	
Name of Physician (please print) _____				
Physician's Address _____				
MVP ROCHESTER OFFICE USE ONLY	<input type="checkbox"/> Not Approved – Reason: _____			
	<input type="checkbox"/> Approved: Effective date _____ End Date _____			
	Reviewer _____	Date _____	Processed by _____	Date _____