Application For Continuation Of Coverage for a Disabled Dependent Child

ConnectiCare

Subscriber Information

Subscriber Number: _____ Employer: _____

Last Name: _____ First Name: _____ M.I.: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

I hereby apply for ConnectiCare coverage for my disabled child named below:

Last Name: _____ First Name: _____ M.I.: _____

Member#_____ Sex: ☐ Male ☐ Female

Date of Birth: __/__/__

ConnectiCare Primary Care Physician: _____

- Is he/she chiefly dependent on you for support? ☐ Yes ☐ No
- Is he/she a full-time student? ☐ Yes ☐ No
- If yes, name of school: _____
- Has he/she ever been gainfully employed? ☐ Yes ☐ No; If yes, last day actively at work: _____/____/_____

Name and address of employer _____

_____

- Does he/she have any other health insurance coverage? ☐ Yes ☐ No

If yes; name of Insurance Carrier: _____

Name of Policy Holder:_____

Policy Number: _____

- Is this an Employer Group Health Plan? ☐ Yes ☐ No;

If yes, name of employer: _____

I authorize any physician or other health care provider that has diagnosed or rendered treatment for the above-named dependent to furnish ConnectiCare full information relating to such diagnosis or treatment.

Subscriber's Signature

_____

*Dependent Child's Signature

_____

* Your dependent child's signature may be required by the evaluating physician/health care provider. To avoid any delay in processing, if your child is capable of doing so, please have him/her sign above.

Page TWO to be completed by Dependent's physician

This Section To Be Completed By Dependent's Physician

Child's Name: _____ **Subscriber ID #:** _____

Date of last examination: _____

- Specific diagnosis of disabling condition:_____

  _____

  If the disability is due to a mental handicap, attach appropriate documentation (e.g., nature of the handicap, IQ level, date last determined). We will let you know if we need additional information to process this request. To help us with timely and accurate processing, please respond to requests at your earliest convenience.

- Extent/Severity of disability:_____
- Prognosis of disabling condition: _____
- How long has this disability been present?_____
- Is the condition expected to be of long continued or indefinite duration? ☐ Yes ☐ No

1. As the dependent's physician, I certify that the dependent is incapable of self-sustaining employment because of a mental or physical handicap. ☐ Yes ☐ No
2. I certify that the above statements relative to the dependent named on this form are true to the best of my knowledge and belief.

Evaluating Physician's Signature: _____ Date: ___/___/___

Evaluating Physician's printed name and address: _____

_____

Return form to:
ConnectiCare Small Group Administration
c/o CBIA Service Corp
350 Church Street
Hartford, CT 06103-1126
Fax: 860-278-0883

ConnectiCare - Internal Use Only:

New Application: ☐ **Renewal/Continuation:** ☐

Additional Information Necessary (Describe): _____

Additional Information Requested By: _____

Date: _____ **Decision:** _____

Reason: _____

Disability Term: ☐ 2 years ☐ 4 years ☐ Other _____

Name: _____ **Date:** ___/___/_____

Additional Comments: _____

_____

_____

_____

ConnectiCare

Language & Non-Discrimination Notice

ConnectiCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ConnectiCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ConnectiCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, including qualified interpreters and information in alternate formats.
- Provides free language services to people whose primary language is not English, including translated documents and oral interpretation.

If you need these services, contact The Committee for Civil Rights.

If you believe that ConnectiCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

The Committee for Civil Rights, ConnectiCare, 175 Scott Swamp Road, Farmington, CT 06032, Phone: 1-800-251-7722, and TTY: 711. You can file a grievance in person or by mail. If you need help filing a grievance, The Committee for Civil Rights is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Continued →

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-251-7722 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-251-7722 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-251-7722 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-251-7722 (TTY: 711）。

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-251-7722 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-251-7722 (ATS: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-251-7722 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-251-7722 (телетайп: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-251-7722 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-251-7722 (رقم هاتف الصم والبكم: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-251-7722 (TTY: 711)번으로 전화해 주십시오.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-251-7722 (TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-251-7722 (TTY: 711) पर कॉल करें।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-251-7722 (TTY: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-251-7722 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-251-7722 (TTY: 711)។

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-251-7722 (TTY: 711).