115 W. Wausau Ave
Wausau, WI 54402

ADDRESSEE'S NAME TITLE COMPANY NAME STRRET ADDRESS CITY, STATE ZIP CODE	February 7, 2019

Enclosed you will find an Application for Continuation of Coverage for Disabled Adult Dependents. These documents must be completed by you and your dependent's treating physician.

Please complete and return the enclosed Employee and Physician forms within 30 days from the date of this letter. You must submit written proof that your dependent child is totally disabled within 30 calendar days after the day coverage for the dependent would normally end.
Failure to provide the requested information will result in termination of coverage for this dependent.

Please contact UMR Enrollment Services at 866-829-0873 if you have any questions.

Enrollment Services
444 letter

APPLICATION FOR CONTINUATION OF COVERAGE FOR DISABLED ADULT DEPENDENTS

This is to certify that the dependent named above is
1) unmarried,
2) mentally or physically incapable of earning his/her own living as defined in the plan,
3) became mentally/physically disabled before reaching the limiting age for coverage of dependent children under this plan, and
4) is chiefly dependent upon me for support and maintenance.

1) What is the nature of the disability and when did it commence?

_____
_____

2) Do you provide more than 50 percent of this dependent child's support? __Yes __No

3) Was or is the dependent employed?
If yes, please provide the address of the current or last employer:

_____
Dependent's Occupation : _____
Period of employment : _____
Average weekly earnings: _____

4) Was this dependent child ever institutionalized for a mental or physical disability?
__Yes __No
If yes, please provide the name and address of the institution and the period of confinement.

_____
_____

5) Is the dependent eligible for care under federal, state or local Medicare? _____
If yes, please provide details as well as Medicare claim numbers, HIB suffix, effective dates of Medicare eligibility and copy of the Medicare card:

_____
_____

6) Please provide as many of the following documents as possible to support level of functioning and severity of disability:

- Any diagnostic test results/reports for IQ and cognitive functioning. Include from past testing performed by school or providers. There are usually a battery of tests that indicate functioning in all areas and level of disability from the developmental and mental standpoint.
- All records for the past 12 months from any mental health provider if the disability is mental.
- Any vocational rehab test results, the most recent physical therapy evaluation and functional capacity evaluations showing physical limitations if the disability is physical.
- The most recent complete medical history and physical report.
- Legal Guardianship papers. Please confirm whether or not these documents have been obtained indicating that the dependent is incapable of making decisions for own well-being. If they are available, please forward for review. "Legal Guardian" means a person recognized by a court of law as having the duty of taking care of the person and manage the property and rights of a minor child and may be appointed for a disabled person or dependent.

UMR

7) What are the living circumstances of the dependent: at home with parents, assisted living, board and care, etc.?

_____
_____
_____

8) Has the dependent been determined disabled by the Social Security Administration?
__Yes __No
If yes, please provide a copy of the supporting documentation.

With respect to the above named dependent, I hereby request continuation of group health benefits which would otherwise terminate on attainment of the limiting age under the group plan. UMR is authorized to contact my dependent's attending physician and obtain the necessary information concerning my dependent's disability. (Note: any fee for the completion of this form in the responsibility of the member.)

Physician's Name: _____
Address : _____
City State Zip: _____
Phone : _____

UMR reserves the right to require due proof of such disability at any time.

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The continuation of coverage for the dependent requested will terminate on one of the following dates, whichever occurs first:
1) the date of
cessation of such disability,
2) the date of failure to furnish any required proof of the uninterrupted continuation of such disability, or

3) the date of termination of coverage as to the dependent, for reason other than attainment of the limiting age, as provided in the plan.

Signature of parent or legal guardian: (I understand that it is fraudulent to fill out this form with information I know is false or to omit information I know is important.)

Signature: _____
Date : _____

To Be Completed By Physician

Time Sensitive Material Action Required

We have received an Application for Continuation of Coverage for Incapacitated Children form for &re. Before extended coverage can be considered, the following information is needed to determine incapacitated status: (Note: Any fee for the completion of this form is the responsibility of the member.)

1) Is this dependent presently incapable of self-sustaining employment by reason of:
(Check all that apply)
__Mental Disability
__Physical Disability
__Developmentally Disabled

2) Date dependent became incapable of self-sustaining employment:
_____

3) In your opinion, will this dependent ever be capable of self-sustaining employment?
__Yes __No

4) Current Diagnosis and date of onset, staging if applicable
_____

5) Current full AXIS 5 diagnosis and vocational evaluation
_____

6) Was the condition the result of an accident? ___Yes ___No
Date of Accident:_____

7) Dependents IQ (Mental Disability Only) _____

8) Current treatment plan, including medications _____

9) School(s) attend (ed) (ing) regularly including Dates _____

10) Education Status: _____

11) Work ability: _____

12) Provide the most recent history and physical
_____

13) Referral to specialist? Please give name and contact information_____

14) What is the patient's prognosis? _____

15) Are there any other health problems?
_____

Please use the below space for remarks; please give as much detail as possible, including full details of the condition causing the dependent status and a description of the mobility of the patient. If mental disability is present, give the degree of disability. Please include dates and reports of surgery, x-rays, electrocardiograms, or other special tests. Attach additional sheets if necessary.

_____
_____
_____
_____
_____
_____

If admitted as an in-patient, give name and address of hospital:

Name of hospital: _____
Address : _____
_____
Date admitted : _____
Attending M.D. : _____

Enclosed please find a copy of the incapacitated form signed by our member authorizing us to contact &re attending physician to obtain any new information for further review.

Please return the above information within 14 days to UMR, Enrollment Services, PO Box 8052, Wausau, Wisconsin 54402-8052.

Please contact us at 1-866-829-0873 if you have any questions.

Thank you for your assistance.

Signature of Physician: _____ Date signed: _____

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