5381 Green Street
Murray, UT 84123
801-442-5038/800-538-5038
www.selecthealth.org

selecthealth

Application for Extension of Over Aged Dependent Child Coverage

PART I — TO BE COMPLETED BY THE SUBSCRIBER OR GUARDIAN

Please complete all sections. Initial extension of coverage, if granted, is for a minimum of two years. After initial extension, it is necessary to submit a physician's statement for a disabled dependent child annually unless otherwise requested. Forms must be submitted with all supporting clinical documentation within 90 days of last physician appointment.

A. SUBSCRIBER INFORMATION

Subscriber's Name _____ Subscriber ID# _____ (LOCATED ON ID CARD) Date of Birth _____

Address _____ Unit/Apt.# _____

City _____ State _____ ZIP _____ Ph# (_____)_____

Employer _____

B. DEPENDENT INFORMATION

LAST NAME	FIRST NAME	INITIAL	SEX	RELATIONSHIP	DATE OF BIRTH DD/MM/YY	LEGALLY MARRIED Y/N

1. **Does the dependent reside in your home?** ❑ **Yes** ❑ **No**
2. **If the dependent does not reside in your home, does he/she live independently?** ❑ **Yes** ❑ **No**
   Dependent's Address (if different from Subscriber's) _____
3. **What is the nature of the dependent's mental or physical incapacity?** _____
   _____
4. **When did the illness or injury begin?** _____
5. **Has the dependent been continuously incapable of self-support since that date?** ❑ **Yes** ❑ **No**
   If no, please explain _____
   _____
6. **Has the dependent received a vocational assessment from the State Rehabilitation Service?** ❑ **Yes** ❑ **No**
   If yes, please submit a copy
7. **Has the dependent ever been able to do full or part-time work of any kind since the illness or injury began?** ❑ **Yes** ❑ **No**
   If yes, from what date? _____
   What types of work has the dependent performed? _____
   Dependent's current employment status ❑ Not employed ❑ Employed part-time ❑ Employed full-time
8. **Is the dependent claimed as your dependent for federal and state income tax purposes, or is he/she dependent on you for more than one-half of his or her support as defined by the Internal Revenue Code of the United States?** ❑ **Yes** ❑ **No**
   If yes, has the IRS or State confirmed dependency of the child? ❑ Yes ❑ No
   If yes, when was the dependency status reviewed? _____
9. **The dependent is receiving an estimated total income of $ per month from** ❑ **SSI** ❑ **Work** ❑ **Other**
10. **Has the dependent been continuously enrolled with no break of more than 63 days under any form of health care coverage since his or her 26th birthday?** ❑ **Yes** ❑ **No**
11. **Did the dependent become disabled before reaching age 26?** ❑ **Yes** ❑ **No**

C. SIGNATURE

I CERTIFY THAT THIS INFORMATION FURNISHED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. IF THESE CIRCUMSTANCES SHOULD CHANGE IN ANY WAY, I WILL INFORM MY EMPLOYER OR SELECTHEALTH. I CONFIRM THAT EACH SIGNATURE BELOW WAS ENTERED BY THE ACTUAL PERSON OR THEIR LEGAL REPRESENTATIVE. IF THE SIGNATURE WAS ENTERED BY SOMEONE OTHER THAN THE ACTUAL PERSON OR THEIR LEGAL REPRESENTATIVE, I MAY BE PENALIZED, INCLUDING CANCELATION OF MY SELECTHEALTH INSURANCE POLICY.

Subscriber or Guardian Signature _____ **Date** _____

Dependent Signature _____ **Date** _____

Please email or fax completed documents to:

Fax #: **385-297-2064** • Email: **LargeGroupEnrollment@selecthealth.org**

(continued on other side)

PART II — TO BE COMPLETED BY THE DEPENDENT'S PHYSICIAN

Please complete the statement in reference to the dependent named in Part I of this form.

A. MEDICAL QUESTIONNAIRE

Patient's Name _____ Date of Birth _____

1. Diagnosis _____

_____

_____

2. When did present illness begin or injury occur? _____

3. Treatment _____

_____

_____

4. Please provide a statement describing the patient's functional capacity _____

_____

_____

_____

_____

5. Degree of disability

Is this patient able to do full or part-time work of any kind? ❑ Yes ❑ No If yes, what type? _____

If not, when do you think the patient may be able to do some work of any kind? _____

Is the patient capable of self-support? ❑ Yes ❑ No

6. The patient is presently ❑ Ambulatory ❑ Hospital-confined ❑ House-confined ❑ Bed-confined

7. Progress ❑ Recovered ❑ Improved ❑ Unimproved ❑ Retrogressed

8. Prognosis _____

_____

9. Please attach current supporting doctor's notes.

B. PHYSICIAN SIGNATURE

Physician's Name (Print) _____ Ph# (_____)_____

Address _____

City _____ State _____ ZIP _____

Signature _____ Date _____

Fair Treatment Notice

SelectHealth complies with Federal civil rights laws. We do not discriminate or treat you differently because of your race, color, national origin, age, disability, or sex.

We provide free:

- Aid to those with disabilities to help them communicate with us, such as sign language interpreters and written information in other formats (large print, audio, electronic formats, other).
- Language help for those whose first language is not English, such as Interpreters and member materials written in other languages.

For help, call SelectHealth Member Services at **1-800-538-5038** or SelectHealth Advantage Member Services at **1-855-442-9900** (TTY Users: 711).

If you feel you've been treated unfairly, call SelectHealth 504/Civil Rights Coordinator at **1-844-208-9012** (TTY Users: 711) or the Compliance Hotline at **1-800-442-4845** (TTY Users: 711). You may also call the Office for Civil Rights at **1-800-368-1019** (TTY Users: **1-800-537-7697**).

Language Access Services

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth.

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 SelectHealth。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số SelectHealth.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth. 번으로 전화해 주십시오.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́'', t'áá jiik'eh, éí ná hóló', kojį' hódíílnih SelectHealth.

ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नम्ित भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । SelectHealth मा फोन गर्नुहोस्।.

FAKATOKANGA'I: Kapau 'oku ke lea fakatonga, ko e kau fakatonu lea te nau tokoni atu ta'etotongi, pea te ke lava 'o ma'u ia. Telefoni ki he SelectHealth.

ОБАВЕШТЕЊЕ: Ако говорите српски језик, услуге језичке помоћи доступне су вам бесплатно. Позовите SelectHealth.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa SelectHealth.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: SelectHealth.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните SelectHealth.

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل بشركة SelectHealth.

សម្គាល់៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ សូរ៉ោជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ។ គឺអាចមានសំរាប់ អ្នក។ សូមទូរស័ព្ទមក SelectHealth ។

ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez SelectHealth.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。SelectHealth. まで、お電話にてご連絡ください。

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی به صورت رایگان در اختیار شما خواهد گرفت. از طریق شماره تماس SelectHealth.

ATENȚIE: Dacă vorbiți limba română, vă sunt disponibile servicii de asistență pentru această limbă în mod gratuit. Apelați SelectHealth.

ILANI: Ikiwa unazungumza Kiswahili, huduma za usaidizi wa lugha bila malipo, zinapatikana kwako. Piga simu SelectHealth.

SelectHealth: 1-800-538-5038
SelectHealth Advantage: 1-855-442-9900

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