ARBENEFITS Application for Continuation of Insurance Due to Incapacity

Your schedule of benefits allows coverage for a dependent child beyond the limiting age of 26 if the child meets the definition of an incapacitated dependent as defined by the ARBenefits Plan. Any dependent must be on the plan to be considered for continuation.

An incapacitated dependent is defined as an unmarried child who is incapable of performing gainful employment or attending school due to congenital disability, illness (including mental), physical injury or intellectual deficiency, which began before the child reached the limiting age. Additionally, the child must be dependent upon the policyholder for at least 51% of his/her support. The information requested on this form aids in providing Employee Benefits Division (EBD) with the necessary information to make a coverage determination.

If you have any further questions, please contact the EBD at 877-815-1017.

Please make sure both Policyholder and Physician sections included in this form are completed prior to submitting to EBD.

Section 1 - To Be Completed By Policyholder

Policyholder Name (First, Last)			Member ID#
Policyholder Address (number, street, city, state, zip code)			Phone Number
Dependent Name (First, Last)	Gender ☐M ☐F		Dependent Birth Date
Relationship of Dependent to Policyholder	Is Dependent Married? ☐Yes ☐No		Date Disability Began
Dependent Address (if not residing with Policyholder)			
Please Explain why Dependent does not live with Policyholder			

Is Dependent intellectually challenged?	☐Yes	☐No
Is Dependent physically challenged or has special needs?	☐Yes	☐No
Is Dependent mentally ill?	☐Yes	☐No

Is Dependent able to:

Walk?	☐Yes	☐No	Speak?	☐Yes	☐No	Feed Self?	☐Yes	☐No
Bathe Self?	☐Yes	☐No	Dress Self?	☐Yes	☐No	Be left alone?	☐Yes	☐No

Does Policyholder contribute a minimum of 51% to the total support of Dependent?	☐Yes	☐No
Is Dependent incapable of self-sustaining employment?	☐Yes	☐No
Has Dependent ever been employed?	☐Yes	☐No

If yes, please list: Last date of employment: _____ Type of work: _____

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:
Department of Transformation and Shared Services - Employee Benefits Division
PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-683-0983

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Section 2 - To Be Completed Attending Physician

Patient's Name			
Mental Incapacity ☐Yes ☐No	If yes, add IQ Score	Physical Incapacity ☐Yes ☐No	Age at onset of condition/disability
Diagnosis of condition causing incapacity (Please give as much detail as possible and attach documentation of pertinent medical records, if necessary:			
Clinical description to support incapacity:			
Objective findings (current signs, results, and pertinent diagnosis studies):			
Nature of treatment (including surgery, therapy, medications, etc.):			
Remarks and suggestions (other medical conditions or any other information):			

Attending Physician's Name (Please Print)	Attending Physician's Signature	Date
Attending Physician's Address	Attending Physician's Phone Number	

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Average number of hours worked per week: _____

Is Dependent able to attend school? ☐Yes ☐No

If yes, is Dependent currently attending school? ☐Yes ☐No

If yes, how many hours/day? _____ How many days/week? _____

If the Dependent is currently not attending school, has the Dependent ever attended school? ☐Yes ☐No

If yes, what was he highest grade completed? _____

At what age and/or grade level does the Dependent currently function? _____

Please attach documentation such as school records or court orders of disability or incapacitation and/or any other pertinent information which describes the Dependent's condition.

Is the Dependent covered by any other insurance including: Medicare, Medicaid, TEFRA, etc? ☐Yes ☐No
(Please attach a copy of their card.)

Name of insured: _____ Policy #: _____ Effective Date: _____

Name and address of insurance company: _____

_____

I understand and agree that: 1) the information provided on this application is accurate and complete; 2) any omissions or incorrect statements made by myself or anyone on this application may invalidate my and/or my Dependent's coverage; 3) Coverage will become effective only on the date specified by the insurer, after the application has been approved by the insurer and after the first full premium has been paid; 4) my signature authorizes "coordination of benefits" under this coverage with other insurance I have that is subject to coordination; 5) I hereby authorize deductions from my earnings of any required insurance contribution; 6) my eligibility and/or eligibility of any covered dependents may by audited by EBD, or other designated party, at any time.

Authorization to Obtain Medical Information: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/insurer or any of their designees, and all records or information pertaining to medical history or services rendered to the health plan/insurer, for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purpose, including evaluation of any application or a claim. I also authorize, on behalf of the health plan/insurer, the use of a social security number for a purpose of identification.

Any person who knowingly obtains health coverage when not eligible for coverage, presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines, prison time, repayment for plan losses/claims, or loss of health coverage for life.

Name of Policyholder (Print)	Signature of Policyholder	Date

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