Certificate of Disability for the Handicapped Children's Provision for Continuation of Coverage under the Local No. 9 IBEW and Outside Contractors Health and Welfare Trust (the "Plan")

One Westbrook Corporate Center, Ste 430 • Westchester IL 60154
866-661-1021 toll-free • 708 449 9004 phone • 866 870 6645 fax

Name of Handicapped Child	Date of Birth	Social Security Number

Please review the following statement and complete item (4):

This is to certify that the child named above fulfills the following requirements:

(1) is my unmarried child;

(2) is mentally and/or physically incapable of earning his/her own living;

(3) became so incapable prior to the attainment of the limiting age for a child's coverage under the Plan; and

(4) is financially dependent upon me for _____% of his/her support and maintenance (not including government assistance).

With respect to this child, I am requesting the continuance of the dependent's coverage clause which would otherwise terminate on the date of this child becoming ineligible for coverage under the Plan because of age.

I understand that the Plan reserves the right to examine my child, at its own expense, and if this continuance of coverage is approved, such coverage for this child would terminate as of the date of recovery, or if any of the above four conditions are no longer satisfied:

The above named child has been covered as an eligible Dependent since _____
(date)

I hereby authorize any physician, hospital, pharmacy, insurance company, employer, or organization to release any information regarding medical history, treatment, or disability to the Plan for purposes of validating and determining coverage available in connection with the application. Date without personal identification may be extracted for use in statistical studies.

This authorization shall be valid for one year from the date of authorization.

Signature of Member	BCBS ID Number	Date

Authorization (signature) of Fund Administrator	Date

Attending Physician's Statement of Disability

Name of Patient	Date of birth
Street address	City, State, Zip

History

When did symptoms first appear or accident occur? (mm/dd/yyyy)	Date patient ceased work because of disability (if applicable) (mm/dd/yyyy)	
Had patient ever had same or similar condition? ___No ____Yes (if yes, state when and describe)	Date	Description

Present Condition

Did this incapacity exist prior to the dependent's 19th birthday? ____No ____Yes

Subjective symptoms:

Objective symptoms (include results of EKG's, current X-rays, or any other special tests):

Is the patient (check all that apply): ___Ambulatory ___Bed-confined ___House confined ___Hospital confined

Diagnosis

Treatment

Date of first visit (mm/dd/yyyy)	Date of last visit (mm/dd/yyyy)
Frequency of visits ___Weekly ___Monthly ____Other:	When did you last examine this patient? (mm/dd/yyyy)
Degree of psychiatric impairment ___None ___Mild ___Moderate ___Severe	Degree of physical impairment ___None ___Mild ___Moderate ___Severe
Is the patient capable of holding self-sustaining employment at this time? ____No ____Yes (if yes, please comment at right)	Comment:

Hospitalization

Name of hospital(s), if ever admitted as an in-patient	**Admission Date(s)**	**Discharge Date**

Progress

___Recovered ___Improved ___Unimproved ___Retrogressed

Attending Physician Information and Signature

Signature of Attending Physician	Printed name of Attending Physician
Date	Degree(s) earned
Social Security or Tax ID Number	Telephone
Street address	City, State, Zip