



**REQUEST FOR CONTINUED COVERAGE
FOR INCAPACITATED CHILD
NORTHERN CALIFORNIA TILE INDUSTRY
HEALTH & WELFARE TRUST FUND**

P.O. Box 2500
San Francisco, CA 94126
415/986-6276

TO BE COMPLETED BY ATTENDING PHYSICIAN

Note: Any fee for the completion of this form is the responsibility of the employee.

PATIENT'S NAME	DATE OF BIRTH
DIAGNOSIS (BE AS DETAILED AS POSSIBLE)	<input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE

TREATMENT

DATE OF FIRST TREATMENT	WHEN DID YOU LAST TREAT PATIENT?
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LIST OF MEDICATIONS TAKEN FOR DISABLING CONDITION

Submit clinical summary and/or current supporting documentation of disabling condition. For mental conditions, include current IQ test results if available.

EXTENT OF DISABILITY

IS PATIENT NOW INCAPABLE OF SELF-SUPPORT BECAUSE OF A DISABILITY? YES NO

INDICATE CURRENT FUNCTIONAL CAPABILITIES AND LIMITATIONS

HAS SUCH DISABILITY EXISTED CONTINUOUSLY SINCE BEFORE THE PATIENT ATTAINED AGE 19?

YES NO

DO YOU THINK PATIENT WILL BE ABLE TO RETURN TO GAINFUL EMPLOYMENT?

YES, INDICATE APPROXIMATE DATE: INDEFINITE NEVER

PHYSICIAN NAME		PHYSICIAN PHONE	
PHYSICIAN ADDRESS	CITY	STATE	ZIP

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of Physician

Date

INTERNAL OFFICE USE ONLY



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TO BE COMPLETED BY COVERED EMPLOYEE

EMPLOYEE'S NAME		SOCIAL SECURITY NUMBER	DATE OF BIRTH	
HOME ADDRESS		CITY	STATE	ZIP
GROUP NAME			TELEPHONE NUMBER	
EMPLOYER			DATE OF HIRE	

INFORMATION ABOUT INCAPACITATED CHILD

CHILD'S NAME		RELATIONSHIP TO EMPLOYEE
DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	CHILD'S AGE WHEN DISABILITY OCCURRED
DESCRIBE DISABILITY		

IS CHILD DEPENDENT ON YOU FOR SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE INDICATE PERCENTAGE SUPPORT:
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IS CHILD LISTED AS A DEPENDENT ON YOUR LAST FEDERAL INCOME TAX RETURN? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF NO, PLEASE INDICATE WHY NOT:

IS CHILD PERMANENTLY RESIDING IN YOUR HOUSEHOLD? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF NO, PLEASE INDICATE WHY NOT:

IS THIS DEPENDENT CURRENTLY A FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME OF SCHOOL	HOURS ATTENDED DAILY

IS CHILD RECEIVING SOCIAL SECURITY DISABILITY INCOME? <input type="checkbox"/> YES <input type="checkbox"/> NO
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IS CHILD COVERED UNDER ANY OTHER HOSPITAL OR MEDICAL COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, PLEASE GIVE NAMES OF INSURANCE COMPANIES AND POLICY NUMBERS

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Signature of Employee _____	Date _____
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