Department of Transformation and Shared Services
Governor Asa Hutchinson
Secretary Amy Fecher
Director Jake Bleed

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 ARBenefits Plan.

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 percent of his/her support. The information requested on this form aids in providing ARBenefits with the necessary information to make a coverage determination.

If you have any further questions, please contact the Employee Benefits Division at 501-682-9656.

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's Name:		*ARBenefits Member ID #:*
Policyholder's Address (number, street, city, state and Zip Code):		Policyholder's Phone Number:
Dependent's Name:	Sex: ☐ Male ☐ Female	Dependent's Date of Birth:
Relationship of Dependent to Policyholder:	Is Dependent Married? ☐ Yes ☐ No	Date Disability Began:
Dependent's 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 the Policyholder contribute a minimum of 51% to the total support of the Dependent?	☐ Yes	☐ No
Is Dependent incapable of self-sustaining employment?	☐ Yes	☐ No
Has Dependent ever been employed? If yes, please give:	☐ Yes	☐ No

Last date of employment:_____ Type of work:_____.

Average number of hours worked per week:_____.

Is Dependent able to attend school? ☐ Yes ☐ No

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

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

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

If yes, what was the highest grade level 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) That my eligibility and/or the eligibility of any covered dependents may be audited by EBD, or other designated party, at any time. (7) By signing this form, I hereby certify that all the information provided is true and correct.

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, any 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 an 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, confinement in prison, repayment for plan losses/claims, or loss of health coverage for life.

_____	_____	_____
Name of Policyholder (please print)	Signature of Policyholder	Date

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SECTION 2 – TO BE COMPLETED BY 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 or pertinent diagnosis studies):			
Nature of treatment (including surgery, therapy, medications, etc.):			
Remarks and Suggestions (Other medical conditions and any other information that would enable us to make a determination of the dependent's incapacity.):			

Attending Physician's Name (please print)	Attending Physician's Signature/Date:
Attending Physician's Address	Attending Physician's Phone Number:

Please return completed application to:

Employee Benefits Division
PO Box 15610
Little Rock, AR 72231-5610
Or FAX to: 501-683-0983

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EBD Use Only

☐ Approved

☐ Denied

Date: _____

Reason for denial: