Thank you for asking about coverage for your dependent, who may be eligible to receive health coverage under your contract or certificate.

According to New York State Insurance Law, continued coverage for your dependent may be considered, if he or she:

- Is not married
- Is disabled due to mental illness*, mental retardation**, developmental disability*** or physical handicap****
- Became disabled before reaching the age at which dependent coverage would otherwise terminate
- Is incapable of self-sustaining employment***** due to the disability, and proof of such incapacity is sent within 31 days of reaching the coverage termination age.

*****The inability to find employment or a reduction in work capability is not, in itself, evidence of eligibility. If a mentally retarded, mentally ill, developmentally disabled, or physically handicapped dependent is working, the extent of his or her earning capacity will be evaluated. He/she must be chiefly dependent upon the subscriber for support and maintenance.

If you believe your dependent meets all the above criteria, please complete Section 1 of the form and return it with supporting paperwork. Have your dependent’s doctor complete Section 2 and include at least six months of documented evaluation that demonstrates how your dependent’s disability prevents any form of self-sustaining employment and that accommodation is not possible.

Return your completed paperwork to:

**HIP Health Plan of New York**
PO Box 2794
New York, NY 10116-2794

Please note that we will not be able to continue coverage for your dependent unless we receive, review and approve your paperwork within 31 days of your dependent reaching the termination age.

Thank you for your continued interest in HIP.

Sincerely,

Marilyn DeQuatro
Senior Vice President
Customer Service Division
**Mental Illness:** This term refers to a mental disease or mental condition that is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation. It does not include alcoholism, substance abuse and chemical dependence.

**Mental Retardation:** This term refers to subaverage intellectual functioning that originates during the developmental period and is associated with impairment in adaptive behavior.

**Developmental Disability:** This term refers to a disability of a person that:

(a) (1) Is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia or autism;

   (2) Is attributable to any condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of a mentally retarded person or requires treatment and services similar to those required for such person; or

   (3) Is attributable to dyslexia resulting from a disability described in subparagraph (1) or (2) of this paragraph;

(b) Originates before such person attains age 22;

(c) Has continued or can be expected to continue indefinitely; and

(d) Constitutes a substantial handicap to such person’s ability to function normally in society.

**Physical Handicap:** This term refers to a condition, function or physical disability that makes participation in certain usual activities of daily living difficult or impossible. A physical handicap may be present at birth or develop over an individual’s lifespan.
REQUEST FOR COVERAGE FOR DEPENDENT CHILD OVER THE DEPENDENT AGE LIMIT

According to New York State Insurance Law, continued coverage for your dependent may be considered, if he or she:

- Is not married
- Is disabled due to mental illness, mental retardation, developmental disability or physical handicap as defined below
- Became disabled before reaching the age at which dependent coverage would otherwise terminate
- Is incapable of self-sustaining employment* due to the severity of the disability and proof of such incapacity has been submitted within thirty-one days of attaining the termination age.

*The inability to find employment or a reduction in work capability is not, in itself, evidence of eligibility. If a mentally retarded, mentally ill, developmentally disabled, or physically handicapped dependent is working, the extent of his or her earning capacity will be evaluated. He/she must be chiefly dependent upon the subscriber for support and maintenance.

SECTION 1 – TO BE COMPLETED BY SUBSCRIBER

<table>
<thead>
<tr>
<th>Group Number</th>
<th>Group Type</th>
<th>Group Name</th>
<th>Subscriber HIP Number</th>
<th>Subscriber Name</th>
<th>Phone Number</th>
<th>Address of Subscriber (Number and Street)</th>
<th>Apt Number</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Dependent HIP Number</th>
<th>Dependent Name</th>
<th>Does the dependent permanently reside with the subscriber? YES NO</th>
<th>If NO, explain</th>
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</table>

<table>
<thead>
<tr>
<th>Dependent Date of Birth</th>
<th>Dependent Relationship to Subscriber</th>
<th>Dependent Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month    Day         Year</td>
<td>Son  Daughter Other ____________</td>
<td>Single  Widowed Married Divorced</td>
</tr>
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</tbody>
</table>

Was the dependent ever institutionalized? YES NO

If YES, give Name and Address of Institution(s) Period of Confinement: From: To

Is the dependent eligible for care under federal, state, local Medicare? YES NO

If YES, give details Effective Date of Medicare Eligibility Part A Part B

Was the dependent ever employed for wages? YES NO

If YES, give name/address of current or last employer Average Weekly Earnings $ Date of Employment From To

Is the dependent a full-time student? YES NO

School Attending Enrollment Dates: From To

Is the dependent on medical leave from school? YES NO Does dependent plan to return to school? YES NO Return to school date: / / 

I understand that failure to complete this form may result in a delay, denial or termination of coverage for the above-named dependent. I understand that HIP reserves the right to ask for more information concerning the dependent’s disability status. I agree to notify HIP promptly of any change in my dependent’s disability status.

Subscriber’s Signature Date Signed
SECTION 2 TO BE COMPLETED BY PHYSICIAN – In order to ensure continued benefits for your patient, please answer each question regarding his/her disabling clinical condition. Attach supporting documentation.

**Mental Illness:** This term refers to a mental disease or mental condition that is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation. It does not include alcoholism, substance abuse and chemical dependence.

**Mental Retardation:** This term refers to subaverage intellectual functioning that originates during the developmental period and is associated with impairment in adaptive behavior.

**Developmental Disability:** This term refers to a disability of a person that:

(a) (1) is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment familial dysautonomia or autism;
(2) is attributable to any condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of mentally retarded persons or requires treatment and services similar to those required for such persons; or
(3) is attributable to dyslexia resulting from a disability described in subparagraph (1) or (2) of this paragraph;

(b) originates before such person attains age twenty-two (22);

(c) has continued or can be expected to continue indefinitely; and

(d) constitutes a substantial handicap to such person’s ability to function normally in society.

**Physical Handicap:** This term refers to a condition, function or physical disability that makes participation in certain usual activities of daily living difficult or impossible. A physical handicap may be present at birth or develop over an individual’s lifespan.

<table>
<thead>
<tr>
<th>Is this dependent capable of self-sustaining employment?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>If NO, select the reason(s):</td>
<td>MENTAL RETARDATION</td>
<td>MENTAL ILLNESS</td>
</tr>
<tr>
<td></td>
<td>PHYSICAL HANDICAP</td>
<td>DEVELOPMENTAL DISABILITY</td>
</tr>
<tr>
<td>When did the incapacity begin?</td>
<td>Date of your most recent examination of this patient:</td>
<td></td>
</tr>
<tr>
<td>Was the condition the result of an accident?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>If accident, date of accident:</td>
<td>Month:</td>
<td>Year:</td>
</tr>
<tr>
<td>Is the dependent’s condition permanent?</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

**IMPORTANT:** PLEASE INCLUDE I.Q. OF DEPENDENT, WORK ABILITY AND EDUCATIONAL STATUS FOR THIS SECTION CONCERNING DIAGNOSIS OF CONDITION.

1. Diagnosis of disability:

2. Pertinent clinical findings/severity of illness:

3. Functional status:

4. Relevant laboratory and other test results:

5. Current therapy, including special schooling or other rehabilitative services:

In your opinion, will this dependent ever be capable of self-sustaining employment?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>NOT AT THIS TIME</th>
<th>If not, when (approximately)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Attending M.D.</td>
<td>Specialty</td>
<td>Date Signed</td>
<td></td>
</tr>
</tbody>
</table>

Address | Phone Number

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claims for each such violation.

FOR HIP USE ONLY

<table>
<thead>
<tr>
<th>Approved By</th>
<th>Date</th>
<th>Date For Future Review:</th>
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<tr>
<th>Denied By</th>
<th>Date</th>
<th>Denial Reason</th>
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