Michigan Conference of Teamsters Welfare Fund (MCTWF)

2700 Trumbull Avenue, Detroit, Michigan, 48216 ● (313) 964-2400 ● www.mctwf.org

Request for Continuation of Coverage Beyond Age 26 for Totally & Permanently Disabled Dependent

INSTRUCTIONS:

- Complete all sections on this form (front and back)
- Sign the form in sections 10 and 11.
- Ask the dependent's physician to send to you medical records supporting the dependent's total and permanent disability that you must include with this form.
- Send or fax this completed form along with the medical records to:

MCTWF
Trumbull Avenue
Detroit, MI 48216
Fax: 313-496-2936

Coverage will end when:

- The total and permanent disability ends.
- The total and permanent disability can no longer be medically supported.
- Loss of eligibility.

MCTWF Rules for Continuation of Coverage beyond Age 26 for Disabled Dependent

A covered dependent is your natural or step child or child who has been placed with you for adoption, or who you have adopted, regardless of age (except that such child over the age of 26 must be unmarried), who has been determined by a physician, psychologist or psychiatrist to be totally and permanently disabled. Total and permanent disability means the individual has a physical or mental condition that is expected to continue for the remainder of his/her life and that causes him/her to be unable to engage in any regular employment or occupation for compensation, profit or gain for which he/she may be suited for in regards to education, training, or experience. If your disabled dependent child is age 26 or greater and the disability began before the child was covered under the MCTWF Actives Plan, you must present adequate documentation that the child was covered as your dependent under your health plan on the day immediately preceding your MCTWF Actives Plan coverage.

Participant's Statement

This statement must be completed in its entirety.

1. Participant Name:	**2. Participant Contract Number** __ __ __ __ __ __ __ __ __	**3. Address (street, city, state, ZIP code)**
4. Participant's Employer:	**5. Prior Health Insurance Information**: Was the dependent covered under the Participant's prior health insurance? ___Yes ___No If yes, date prior health insurance **started** __ __/__ __/__ __ **ended** __ __/__ __/__ _ mm dd yyyy mm dd yyyy Name and phone number of prior health insurance: _____	

6. Dependent Information:

Name: _____ Date of Birth __ __/__ __/__ __
mm dd yyyy

When did the disability start? Date __ __/__ __/__ __
mm dd yyyy

7. **Physician Information:**
The enclosed medical records supporting dependent's total and permanent disability have been provided by:

Physician's Name: _____ Phone Number:_____

Physician's Address:_____

8. Other Health Insurance Information
Is dependent eligible for any other health insurance including publicly funded health benefits? Yes ____ No ____
If yes, please provide other health insurance information (name, contract number, effective date):
_____

_____

9. Dependent Employment History
Is the dependent currently employed? Yes _____ No _____
If yes, provide the name of the employer(s) and dates of employment.

Name of Employer	Dates of Employment	Hours Worked Weekly	Describe Duties
_____	_____	_____	_____

If dependent has <u>not been employed</u>, how does the dependent's disability prevent employment?

10. **Authorization and Release:** To all providers of health care: You are authorized to release to MCTWF information concerning any health care advice, treatment or supplies provided to the dependent child (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate a request for coverage. This authorization is valid for the duration of eligibility under the MCTWF Actives Plan which this request has been submitted. I know that I have a right to receive a copy of this authorization upon request. And I agree that a photographic copy of this authorization is as valid as the original.

Participant Signature: _____ __ __/__ __/__ __
mm dd yyyy

Dependent Signature:_____ ____/____/_____
mm dd yyyy

11. Statement: I represent that, to the best of my knowledge and beliefs, the statement and answers on this form are complete and correct. I understand that continuation of coverage for a disabled dependent is subject to approval by MCTWF.

Participant Signature: _____ __ __/__ __/__ __
mm dd yyyy

Dependent Signature: _____ ___/____/_____
mm dd yyyy