

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 not been employed, 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