

GUIDELINES AND INSTRUCTIONS

Complete the application on page 2 if you are a C.O.P.S. Health Trust member that would like to continue coverage for an incapacitated dependent.

INCAPACITATED DEPENDENT (DEFINITION FOR C.O.P.S. HEALTH TRUST MEMBERS)

Incapacitated dependents of C.O.P.S. Health Trust members are defined as those unable to earn a living because of developmental disability or physical disability, and must rely on their parents for support and maintenance. For more information on continuing coverage for an incapacitated dependent, please visit www.michigan.gov/employeebenefits.

For questions about incapacitated eligibility, please call the Employee Benefits Division at 1-800-505-5011, Monday through Friday, 8:00 a.m. to 5:00 p.m.

APPLICATION INSTRUCTIONS

If your dependent meets these guidelines, please complete and sign page 2 of this application. Your dependent's physician must complete and sign page 3 of this application.

If you're applying for more than one dependent (e.g., twins), you must complete and mail a separate application for each dependent.

Submit the completed application by email.

Email: vwilson@bluewaterbenefitsadmin.com
Subject: ATTN: Senior Medical Analyst

Once we receive your application, we'll review and determine if your dependent can continue under your state-sponsored benefits as an incapacitated dependent. If your dependent does not meet the State of Michigan's Dependent Eligibility Guidelines, they will be considered ineligible and will be removed from your coverage.

PLEASE COMPLETE THE FORM BELOW. KEEP A COPY OF THE COMPLETED FORM FOR YOUR RECORDS.

SECTION A: SUBSCRIBER INFORMATION					
NAME _____			CONTRACT NUMBER _____		
DATE OF BIRTH (MM/DD/YYYY) _____		MARITAL STATUS ☐ SINGLE ☐ MARRIED		SEX ☐ MALE ☐ FEMALE	
PRIMARY RESIDENCE: STREET ADDRESS _____		CITY _____	COUNTY _____	STATE _____	ZIP CODE _____
OTHER RESIDENCE (IF ANY): STREET ADDRESS _____		CITY _____	COUNTY _____	STATE _____	ZIP CODE _____
HOME PHONE NUMBER _____			DAY TELEPHONE NUMBER _____		
SECTION B: DEPENDENT INFORMATION (PLEASE LIST YOUR INCAPACITATED DEPENDENT)					
FIRST NAME _____		LAST NAME _____		SSN (LAST 4 DIGITS) _____	
RELATIONSHIP _____		SEX ☐ MALE ☐ FEMALE		DATE OF BIRTH (MM/DD/YYYY) _____	
DATE CONDITION DEVELOPED (MM/DD/YYYY) _____		DIAGNOSIS _____			
SECTION C: MEDICARE INFORMATION					
IS THE DEPENDENT ENTITLED TO MEDICARE AS A RESULT OF THIS CONDITION? ☐ YES ☐ NO					
SECTION D: OTHER INSURANCE					
IS THE DEPENDENT CURRENTLY COVERED BY HEALTH INSURANCE OTHER THAN THIS C.O.P.S. HEALTH TRUST PLAN OR MEDICARE? (IF YES, PLEASE COMPLETE BELOW.) ☐ YES ☐ NO					
NAME OF INSURED _____			INSURANCE COMPANY NAME _____		
INSURANCE COMPANY ADDRESS: STREET/P.O. BOX NUMBER _____			CITY _____	STATE _____	ZIP CODE _____
GROUP OR POLICY NUMBER _____		CONTRACT TYPE ☐ SINGLE ☐ FAMILY		POLICY EFFECTIVE DATE (MM/DD/YYYY) _____	
SECTION E: ADDITIONAL INFORMATION					
SECTION F: VERIFICATION					

I am requesting that the dependent listed above be included under my coverage through C.O.P.S. Health Trust. I understand that this dependent may be covered under my coverage if:

- My dependent is incapable of self-support because of a physical or mental incapacity that existed prior to the end of the month he/she turned age 26.
- My dependent relies on me for support and maintenance.

I certify that I have read the entire application. I also certify that the statements and answers given are complete and correct to the best of my knowledge. I have provided supportive documentation on my dependent's disability as requested above and am aware that without proper documentation coverage may be denied. I am also aware that additional information may be required to make a determination of coverage, and that presenting this documentation does not imply automatic coverage.

SUBSCRIBER'S SIGNATURE (DO NOT PRINT)

DATE SIGNED

SECTION G: DEPENDENT'S ATTENDING PHYSICIAN CERTIFICATION (COMPLETED BY PHYSICIAN)

DATE OF FIRST EXAMINATION (MM/DD/YYYY)	DATE OF LAST EXAMINATION (MM/DD/YYYY)	FREQUENCY OF VISITS
_____	_____	_____

DIAGNOSIS/DISABILITY (INCLUDE ICD10 CODE)

CLINICAL INFORMATION: (MEDICAL SUMMARY DOCUMENTING ALL ITEMS LISTED CAN BE ATTACHED TO FORM IN LIEU OF COMPLETING THIS SECTION)

ONSET (SPECIFY DATE)

TEST OR DATA ESTABLISHING DIAGNOSIS

OTHER MEDICAL PROBLEMS

CURRENT MEDICATIONS AND TREATMENT PLAN (INCLUDE EXPECTED DURATION)

IS THIS A PSYCHIATRIC DISABILITY? IF YES, PLEASE COMPLETE THIS SECTION AND ADDRESS THESE ITEMS IN YOUR NARRATIVE REPORT. COMPLETE DSM5 DIAGNOSIS REQUIRED WITH DESCRIPTORS, CODES AND SEVERITY SPECIFIERS:

☐ AXIS I ☐ AXIS II ☐ AXIS III ☐ AXIS IV ☐ AXIS V GAF, CURRENT: _____ GAF, HIGHEST (PAST YEAR): _____

IS THE DEPENDENT ABLE TO INDEPENDENTLY MANAGE HIS OR HER OWN FINANCES? ☐ YES ☐ NO

IS THE DEPENDENT FULLY COMPLIANT WITH TREATMENT? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN. _____

WOULD THE PROGNOSIS BE DIFFERENT IF THE DEPENDENT WERE COMPLIANT? ☐ YES ☐ NO

HAS THE DEPENDENT BEEN HOSPITALIZED FOR A PSYCHIATRIC CONDITION? ☐ YES ☐ NO DATES AND FACILITY: _____

WHAT IS THE NATURE AND DEGREE OF THE DEPENDENT'S IMPAIRMENT IN THEIR CAPACITIES FOR:

DAILY ACTIVITIES? _____

TASK PERFORMANCE? _____

SOCIAL INTERACTION? _____

IF DISABILITY INVOLVES DEVELOPMENTAL DELAY OR INTELLECTUAL DETERIORATION, HAS IQ TESTING BEEN PERFORMED? ☐ YES ☐ NO

RESULTS: _____ DATE PERFORMED (MM/DD/YYYY): _____

IF NOT, WHAT INTELLECTUAL FUNCTIONS CAN BE PERFORMED, E.G. MATH, READING, COMPREHENSION, MEMORY SKILLS)

IS THE DEPENDENT: ☐ AMBULATORY ☐ NON-AMBULATORY ☐ BED CONFINED ☐ WHEELCHAIR CONFINED ☐ HOUSE CONFINED

☐ HOSPITAL/INSTITUTION CONFINED FACILITY NAME _____

PROGNOSIS OF TOTALLY DISABLING CONDITION:
☐ PERMANENT AND TOTAL PERMANENT AND PARTIAL (%) 0%
☐ TEMPORARILY DISABLED WITH EXPECTED RETURN TO FULL FUNCTION (%) RETURN DATE _____

☐ TEMPORARILY DISABLED WITH EXPECTED RETURN TO PARTIAL FUNCTION (%) RETURN DATE _____

IS THE DEPENDENT CAPABLE OF SUPPORTING HIMSELF/HERSELF THROUGH GAINFUL EMPLOYMENT? ☐ YES ☐ NO

SECTION H: VERIFICATION

I certify that the above statements are relative to the disabled dependent named on the reverse side are true and complete to the best of my knowledge and belief.

PHYSICIAN'S NAME

PHYSICIAN'S SPECIALTY

LICENSE NUMBER

PHYSICIAN'S ADDRESS

PHYSICIAN'S SIGNATURE

DATE SIGNED