Barton County Community College Employee Health Care Plan

Application for Coverage of Handicapped Dependent Child

I. The following questions are to be completed by the employee:

Employee's name: _____ Social Security Number: _____
Dependent's name: _____ Social Security Number: _____
Dependent's home address: _____
Is the dependent employed? Yes ☐ No ☐
If yes, please list the name and address of their employer: _____

Is the dependent eligible for health insurance coverage through their employer? Yes ☐ No ☐

Has continuous group health insurance coverage been maintained by this child? Yes ☐ No ☐

If yes, please submit supporting documentation if dependent was previously covered under a group plan other than the College's.
Is the dependent married? Yes ☐ No ☐

Is the dependent primarily dependent on you for support and maintenance? Yes ☐ No ☐

Is the dependent a beneficiary under Medicare? Yes ☐ No ☐

Is the dependent receiving SSA disability benefits? Yes ☐ No ☐

Note: if the dependent is either a beneficiary under Medicare or receiving SSA disability benefits, please submit supporting documentation.
Name of dependent's physician: _____
Address of dependent's physician: _____

Names of other members of the dependent's health care team (rehabilitation or mental health care specialists):
_____

Authorization: I hereby certify that the above listed information is true and correct.

Employee's Signature: _____ Date: _____

Subscribed and sworn before me this _____day of _____, 20___.

_____ My commission expires_____, 20___.
Notary Public

(SEAL)

II. The following questions are to be completed by the dependent's attending physician:

Dependent's name: _____ Date of birth: _____

Diagnosis or condition causing the dependent's disability including the degree of severity: _____

_____

_____

_____

_____

_____

Date of onset of dependent's diagnosis or condition: _____

Date of dependent's last treatment: _____

Prognosis (estimate future duration of condition): _____

_____

_____

_____

_____

Due to disability, is the dependent capable of self-support? Yes ☐ No ☐

Is the dependent now confined to an institution? Yes ☐ No ☐

If yes, please list the name of the institution:_____

Physician's name (please print) : _____

Physician's address: _____

Physician's Signature: _____ Date: _____