Eliance Health Solutions
Lancaster General Health

Please return completed form to:
Eliance Administrators, Attn: Customer Service
P.O. Box 7046, Lancaster, PA 17604-7046
Fax: 717-553-1125
Questions? Call 717-553-1124 or 1-855-408-8503

Application to Request Coverage Continuation for Disabled Dependent

☐ Initial Request	☐ Re-certification

Section A. TO BE COMPLETED BY EMPLOYEE		
Employee (Subscriber) Name:	Group#:	Family ID #:
Employee's Employer:	Date of Birth:	Daytime Phone#:
Dependent's Name:	Dependent's Date of Birth:	
Dependent's address/phone number:		
Dependent's Relationship to Employee: ☐ Biological Child ☐ Adopted Child ☐ Guardianship ☐ Stepchild	Dependent is: ☐ Single ☐ Married ☐ Divorced	
Was Dependent ever employed? ☐ Yes ☐ No	Is Dependent currently employed? ☐ Yes ☐ No	
Was this Dependent claimed as a "dependent" on the Employee's federal income tax filing for the previous year? ☐ Yes ☐ No	**Will** this Dependent be claimed as a "dependent" on the employee's federal tax filing this year? ☐ Yes ☐ No	
Has any else claimed this Dependent for federal income tax purposes? ☐ Yes ☐ No If "yes," who?		
Is this Dependent covered under any other Health Plan, including Medicare, Medicaid or another government-sponsored plan? ☐ Yes ☐ No If "yes," please provide information.		
Nature of Dependent's disability:		
Does disability prevent Dependent from being able to work: ☐ Yes ☐ No	Age when disability occurred:	
Name, address and phone number of Dependent's primary (or attending) physician:		

Name(s), Address(es) and phone number(s) of any other specialist or treating physician:

Section B. EMPLOYEE OR DEPENDENT (as applicable) ATTESTATION

I represent that to the best of my knowledge and beliefs, the statement and answers made by me on this form are complete and correct. I understand that extension of eligibility and benefits for total disability are subject to approval by the Plan based upon the documentation submitted to the Plan in support of this request for extension of eligibility and benefits. I attest that I am not employed in any capacity for pay or profit or in the case of a request for one of my dependents, that the dependent is totally disabled. If this request is approved; I will notify the Plan should the disabling condition resolve prior to the end of the coverage period.

_____ Date: _____

Employee or Dependent Signature (Parent/Guardian required for dependents under age of 17)

Section C. EMPLOYEE OR DEPENDENT (as applicable) SIGNATURE AND RELEASE

To all providers of health care:

You are authorized to provide my health plan and information concerning health care advice, treatment or supplies provided by the individual identified in Section A (including that related to mental/behavioral health, substance abuse and/or HIV/AIDS). This information will be used to evaluate a request for continued eligibility and extension of benefits. This authorization is valid for two years from the date this request was filed. I know I have a right to receive a copy of this authorization upon request.

_____ Date: _____

Employee or Dependent Signature (Parent/Guardian required for dependents under the age of 17)

Caution: Any person who knowingly and with the intent to defraud any health plan or insurance company or other person: (1) files a claim for benefits containing materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent act and may be subject to criminal and civil penalties.

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Section D. TO BE COMPLETED BY ATTENDING PHYSICIAN

The following information is needed in connection with an application for continued health plan coverage for a "disabled dependent." Please provide your full reply and describe the nature and severity of the disability or impairment. Your prompt completion of this form will expedite the disability application process. Any fee for completion of this form and other information is the responsibility of the employee or dependent.

Please include all medical records and the following information:

1. Dependent (patient) name: _____ 2. Diagnosis of disability: _____

3. List any other diagnoses for this patient: _____

_____

4. Estimated expected date of full recovery or partial recovery: _____

5. Severity of disability: ☐ Mild ☐ Moderate ☐ Severe

5. Please attach a narrative (on your letterhead) addressing the following points.

- The history of the specific medical condition(s), including reference to finding from previous examinations, treatment and responses to treatment.
- Clinical findings from your most recent medical evaluation, including findings of physical examinations, results of laboratory tests, x-rays, etc., and other special evaluations or diagnostic procedures and, in the case psychiatric disease, the findings of mental status examinations and results of psychological tests (do not include psychotherapy notes).
- Assessment of the current clinical status and plans for future treatment
- Assessment of the degree to which the medical; condition has or has not become static, well stabilized or controlled, and an explanation of the medical basis for this conclusion.
- Specify the physical and/or mental limitations or restrictions caused by the patient's medical/mental condition(s).
- Does the patient's condition preclude or limit self-supporting employment.? Please explain your answer.
- If the patient is incapable of self-support, at what age did the patient become incapable?
- Can the patient handle his/her own finances?

Physician Name (print): _____

Degree: _____ Specialty Board Certification: _____

Physician's Signature: _____ Date: _____