

STATE OF KANSAS
APPLICATION FOR COVERAGE OF
HANDICAPPED DEPENDENT CHILD

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

- 1. Employee's name _____ Social Security Number _____
- 2. Dependent's name _____ Social Security Number _____
- 3. Dependent's home address _____
- 4. Is the dependent employed? Yes No
If yes, please list the name and address of their employer _____

- 5. Is the dependent eligible for health insurance coverage through their employer?
Yes No
- 6. Has continuous group health insurance coverage been maintained on this child?
Yes No
If yes, please submit supporting documentation if dependent was previously covered
under a group plan other than the State of Kansas.
- 7. Is the dependent married? Yes No
- 8. Is the dependent primarily dependent on you for support and maintenance?
Yes No
- 9. Is the dependent a beneficiary under Medicare? Yes No
- 10. 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.
- 11. Name of dependent's physician _____
- 12. Address of dependent's physician _____
- 13. 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 Signature

Date

Subscribed and sworn to before me this ____ day of _____ 20____

Notary Public My commission expires _____

(SEAL)

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

1. Dependent's name _____ Date of birth _____
2. Diagnosis or condition causing the dependent's disability including the degree of severity

3. Date of onset of dependent's diagnosis or condition _____
4. Date of dependent's last treatment _____
5. Prognosis (estimate future duration of condition)

6. Due to disability, is the dependent capable of self-support? Yes No
7. Is the dependent now confined in an institution? Yes No
If yes, please list the name of the institution _____
8. Physician's name (please print) _____
9. Physician's address _____
10. Physician's signature _____ Date _____