Application for Dependent with Disabilities

1133 SW Topeka Blvd, Topeka, KS 66629-0001
Phone (785) 273-9804 • Toll-free (800) 530-5989
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Complete "Section 1 – Insured's Statement" and "Section 2 – Authorization" below.
The dependent's doctor is to complete "Section 3 – Attending Physician's Statement."
Mail or fax the completed form to Advance Insurance Company of Kansas.

I am applying for continuation of benefits for: ☐ Basic Dependent Life ☐ Voluntary Child Life

Section 1 – Insured's Statement

Employee First Name ____ MI ____

Employee Last Name ____

Employee Social Security Number ____-____-____

Group Number ____

Name of Group Policyholder/Employer ____

Insured Parent's First Name (if not the employee listed above) ____ MI ____

Insured Parent's Last Name ____

Insured's Home Address ____

City ____

State ____ ZIP Code ____ +4 ____

Insured's Social Security Number ____-____-____

Dependent's First Name ____ MI ____

Dependent's Last Name ____

Dependent's Home Address ____

City ____

State ____ ZIP Code ____ +4 ____

Dependent's Social Security Number ____-____-____

Dependent's Date of Birth ____ / ____ / ____

Relationship to Employee ____

Is dependent married? ☐ Yes ☐ No

Are you responsible for the chief support and maintenance of the dependent? ☐ Yes ☐ No

Is the dependent an established beneficiary under Medicare or receiving SSA/SSI disability benefits? ☐ Yes ☐ No
(If yes, complete only Section 1 and include beneficiary verification with this application.)

Has the dependent had any income during the past year? ☐ Yes ☐ No
If yes, please state the following:

Source of Income ____ Amount of Income ____

Is the dependent attending school? ☐ Yes ☐ No
If yes, please state the following:

Name of School ____ Number of Hours Enrolled ____

List your dependent's physician information below:

Dependent's Physician Name ____

Physician's Address ____

City ____

State ____ ZIP Code ____

Physician's Phone Number (____) ____-____

List other members of the dependent's healthcare team (specialist in rehabilitation, mental healthcare provider, etc.) Attach a separate signed and dated listing if needed.

Name ____

Address ____

City ____

State ____ ZIP Code ____

Phone Number (____) ____-____

Please continue on the next page.

Section 2 – Authorization

The above statements are true and complete to the best of my knowledge and belief, and I hereby authorize any hospital or physician who has treated me, other person who has attended me, examined me, or any government agency to furnish to Advance Insurance Company of Kansas (AICK) providing this form, or their representatives, any and all information with respect to any illness, injury, consultations, prescriptions, treatments or benefits and copies of all applicable records. A photostatic copy of this authorization will be as valid as the original. I may revoke this authorization by notifying AICK in writing of my desire to do so. This authorization expires two years from the date signed.

Your signature required

Employee Signature ______________________ Date Signed ____ /____ /______

Dependent or Their Legal Representative ______________________ Date Signed ____ /____ /______

Section 3 – Attending Physician's Statement

Patient Name ______________________ Patient's Date of Birth ____ /____ /______

Disability ICD-9 Code ____________

1. Diagnosis of condition causing disability, indicate degree of severity:

2. Prognosis (estimate in months or years):

3. Is the dependent incapable of self-support by reason of mental or physical disability? ☐ Yes ☐ No

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

If yes, please provide the following details:

Institution Name ____________ Institution Address ____________

City ____________ State ____ ZIP Code ____ Institution Phone Number (____) ____-______

Please print clearly. Your signature is required before this application can be processed.

Physician's Full Name ____________ Physician's Address ____________

Physician's Specialty ____________ Physician's Phone Number (____) ____-______ City ____________ State ____ ZIP Code ____

Your signature required

Physician Signature ______________________ Date Signed ____ /____ /______

Notice

Advance Insurance Company of Kansas will request written proof from time to time related to this child's incapacity and dependence and, when the child is no longer disabled, they will cease to be a dependent and will be ineligible for continued coverage as a dependent.

Warning

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. Report fraud to our Fraud Hotline at (800) 530-5989.