Handicapped Dependent APPLICATION

ADVANCE*
Insurance Company of Kansas
1133 SW Topeka Blvd, Topeka, KS 66629-0001
Phone (785) 273-9804 or Toll-free (800) 530-5989
FAX (785) 290-0727 advanceinsurance.com

Instructions —
1) Complete page 1, "Insured's Statement" and "Authorization" sections.
2) The dependent's doctor is to complete page 2 (on the back), the "Attending Physician's" section.
3) Finally, mail or fax the completed form to Advance Insurance Company of Kansas.

Applying for continuation of benefits for? ☐ Basic Dependent Life ☐ Voluntary Child Life

Section 1 — Insured's Statement

1. Employee's name: (Last) (First) (Middle)	Employee's Social Security No.
2. Name of group policyholder (employer):	Group number:
3. Insured parent's name: (Last) (First) (Middle) (if not the employee in #1, above)	Insured's Social Security No.
4. Insured's home address: (Street) (City) (State) (Zip)	Amount of dependent insurance $
5. Name of Handicapped dependent: (Last) (First) (Middle)	Dependent's Social Security No.

6. Dependent's home address: (Street) (City) (State) (Zip)

7. Dependent's date of birth (MM-DD-YYYY)	Relationship to employee (in #1):	Is dependent married? ☐ Yes ☐ No

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

9. Is the dependent an established beneficiary under Medicare or receiving SSA/SSI disability benefits? ☐ Yes ☐ No
(If yes, complete only Section 1, questions 1through 13 and include beneficiary verification with the application.)

10. Has the dependent had any income during the past year? ☐ Yes ☐ No
If yes, please state the source of the income ____________ and the amount ____________.

11. Is the dependent attending school? ☐ Yes ☐ No
If yes, name of school ____________ and number of hours enrolled____________.

12. Dependent's physician:
Name: ____________
Address: ____________
____
Phone # ____________

13. List other members of the dependent's health care team, i.e. specialist in rehabilitation, mental health care provider, etc. Attach a separate signed and dated listing if the space below is inadequate.
Name: ____________
Address: ____________
____
Phone # ____________

(Signature is required before application can be processed) **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.

Employee sign here X____________ Date signed ____________

Dependent or their Legal Representative
sign here X____________ 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.

*An Independent Licensee of the Blue Cross and Blue Shield Association

Section 2 — Attending Physician's Statement

Patient name:______________________________ **Date of birth**:__________________
(MM-DD-YYYY)

Disability

1. Diagnosis of condition causing disability, indicate degree of severity: ICD-9 Code ____________

____

____

____

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, name of institution:

   ____

   Address: ______________________________

   ____

   Phone # ______________________________

Please print clearly. A signature is required before the application can be processed.

Physician's full name ______________________________ Specialty ______________

Full address ____
(PO Box and Street, City, State and Zip)

Phone no. ( ) ______________________ Fax no. ( ) ______________________

Physician sign here X______________________________ Date signed ______________

— 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 (800) 530-5989.

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