Reply to:
SWSCHP
12 Metro Park Road
Suite 104
Colonie, NY 12205-1139
Attn: Dependent Eligibility

APPLICATION FOR COVERAGE OR CONTINUATION OF COVERAGE FOR DISABLED DEPENDENT

A. Please complete items 1 through 12 in section I and sign this portion of the form.
B. Your employer must complete and sign Section II
C. Have your dependent's doctor complete ALL the questions in Section III and sign his/her documentation.

NOTE: All sections MUST be filled in. Any applications not completed will be returned.

Section I: To be completed by Employee

[ ] Application for Dependent Coverage
[ ] Application for Continuation of Dependent Coverage

Employee Name (Please Print) Last First Middle	Employee Address	Telephone (Area Code)
Employer's Name & Address		

Dependent Name Last First Middle	Date of Birth	Marital Status (Dependent)

Date of first treatment for this illness/injury	Date first totally disabled and unable to work

Has Dependent engaged in any self-sustaining employment since start of disability? [ ] No [ ] Yes
If Yes, dates of employment from to

Name & Address of Dependent's Employer

Name & Address of Dependent's Physician

The above answers are true and complete. I authorize any employer, insurer, medical prepayment plan or hospital or medical service plan, Physician or other medical professional, hospital or other medical or custodial care institution, consumer reporting agency, or attorney to release or obtain from "SWSCHP" any employment, medical or benefit payment information that may be required to determine eligibility for coverage and further authorize said company, person or plan, to disclose any personal claim information required for medical case study or review. A photostat of this authorization shall be as valid as the original. I know that this authorization is valid for three (3)years from the date signed and that I have the right to receive a copy upon request.

____
Dependent's or Authorized Person's Signature Date

Section II: To be completed by Employer

Employee Name (Please Print)	Date Employed	Dependent Name (first and last)	Effective Date of Coverage Employee / Dependent /
If dependent coverage was previously terminated, date terminated Mo / Day / Year / /			

Name of Employer	Employee Social Security Number

Date	By (Signature)	Title

Section III: **ATTENDING PHYSICIAN'S STATEMENT**

All sections A – H must be completed.
The form MUST be signed by the attending physician
Incomplete forms will be returned.

Dear Doctor:
Your patient ____, born ________________ is a dependent of ______________________________________ employed by ____.

The purpose of this report is to assist us in making a disability determination. In filling out this report, please include sufficient details of history, physical and diagnostic findings, clinical course, therapy and response to enable us to make this determination. After completing and signing this form, return it to the Plan or Claim Office listed on the front of the form.

A. History:

- Patient's age ____________________ Diagnosis ____
- History of Present Illness (HPI) When did symptoms first appear or accident happen? Mo._____ Day_____ Year _____
- Date patient became totally disabled (unable to work or perform the normal, common and habitual activities of a person in sound health and of the same age and sex)? Mo.____________ Day____________ Year _______________
- Has patient ever had same or similar condition? Yes [ ] No [ ]
  If "*YES*" state when and give diagnosis
  ____
  ____
- Subjective symptoms **does not apply** [ ]
  ____
  ____
  ____
  ____
- Objective Findings:
  General (height, weight, vital signs)
  ____
  ____
  Skin [ ] Normal [ ] Abnormal (please describe findings)
  ____
  ____
  Eyes [ ] Normal [ ] Abnormal (please describe findings)
  ____
  ____
  Ears, Nose, Mouth and Throat [ ] Normal [ ] Abnormal (please describe findings)
  ____
  ____
  Neurologic [ ] Normal [ ] Abnormal (please describe findings)
  ____
  ____
  Respiratory [ ] Normal [ ] Abnormal (please describe findings)
  ____
  ____
  Cardiovascular [ ] Normal [ ] Abnormal (please describe findings)
  ____
  ____
  Cardiovascular Functional capacity (if applicable)
  [ ] Class 1-no limitations [ ] Class 2-slight limitation [ ] Class 3- marked limitation [ ] Class 4- complete limitation
  ____

Gastrointestinal [ ] Normal [ ] Abnormal (please describe findings)

____

____

Musculoskeletal [ ] Normal [ ] Abnormal (please describe findings) Include amputation(s), functional deficit(s)

____

____

____

____

____

Psychiatric [ ] Normal [ ] Abnormal

If abnormal, please attach a copy of the most recent psychological evaluation including:

- orientation to time, place self.
- Description of thought processes including psychotic thoughts, hallucinations, delusions, preoccupation with violence, homicidal/suicidal ideation and obsessions.
- Description of patient's judgement concerning everyday activities and social situations
- Recent and remote memory
- Attention span and concentration
- Mood and affect
- Fund of knowledge
- Prognosis for improvement

B. Dates of Treatment

- Date of first visit Mo.__________ Day__________ Year __________
- Date of Last visit Mo.__________ Day__________ Year __________
- Frequency Weekly [ ] Monthly [ ] Other (specify) [ ] ______________________

C. Nature of Treatment

- Medications:

  ____

  ____

- Therapy (physical, occupational, speech, psychiatric) *Please indicate frequency of visits*.

  ____

  ____

- Surgery (past and planned for future)

  ____

  ____

- Other (be specific and clear)

  ____

  ____

D. Progress

- [ ] Recovered [ ] Improved [ ] Unchanged [ ] Retrogressed
- Is patient [ ] Ambulatory [ ] House confined [ ] Bed confined [ ] Hospital Confined

  If hospital confined name & address of hospital

  ____

  Dates of confinement from ______________________ to ______________________

E. Physical Impairment

[ ] Class 1 – No limitation of functional capacity; capable of heavy physical activity. No restrictions (0-10%)

[ ] Class 2 – Slight limitation of functional capacity; capable of light manual activity (15-30%)

[ ] Class 3 – Moderate Limitation of functional capacity; capable of clerical/administrative (sedentary) activity (35-55%)

[ ] Class 4 – Marked limitation (60-70%)

[ ] Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary) activity (75-100%)

F. Mental/Nervous Impairment (if applicable)

[ ] Class 1 – able to function under stress and engage in interpersonal relations (no limitations)
[ ] Class 2 – able to function inmost stress situations and engage in most interpersonal relations (slight limitations)
[ ] Class 3 – able to engage only in limited stress situations and engage in only limited interpersonal relations (moderate limitations)
[ ] Class 4 – unable to engage in stress situations or engage in interpersonal relations (marked limitations)
[ ] Class 5 - significant loss of psychological, physiological, personal and social adjustment (severe limitations)

G. Impact on life activities

Please list how the following activities are impacted by the patient's injury/illness:

Self care: Personal hygiene…[ ] Independent [ ] Needs minimal assistance
[ ] Needs moderate assistance [ ] Totally dependent on others

Dressing…………[ ] Independent [ ] Needs minimal assistance
[ ] Needs moderate assistance [ ] Totally dependent on others

Food preparation…[ ] Independent [ ] Needs minimal assistance
[ ] Needs moderate assistance [ ] Totally dependent on others

Eating ……………[ ] Independent [ ] Needs minimal assistance
[ ] Needs moderate assistance [ ] Totally dependent on others

Personal business: money management ...[ ] Independent [ ] Needs minimal assistance
[ ] Needs moderate assistance [ ] Totally dependent on others

Social activities………………..[ ] Independent [ ] Needs minimal assistance
[ ] Needs moderate assistance [ ] Totally dependent on others

Leisure & recreational activities.[ ] Independent [ ] Needs minimal assistance
[ ] Needs moderate assistance [ ] Totally dependent on others

H. Prognosis

Do you expect a fundamental or marked improvement in the future? [ ] Yes [ ] No

If "YES" when will the patient recover sufficiently to become employed Mo.________ Day______ Year _______

If "no" please explain

____

____

____

____

Remarks

Date	Name (Attending Physician) Please Print		Degree
Address	City/Town	State	Zip Code
Telephone (Area Code)		Fax (Area Code)	
Signature			

Please feel free to attach any additional information you feel would assist us in making our determination.