ALASKA ELECTRICAL HEALTH & WELFARE FUND

Application to Continue Coverage For Handicapped Child

Return form to:
Alaska Electrical H&W Fund
701 E. Tudor, Suite 200
Anchorage, AK 99503
(907) 276-1246 or (800) 478-1246
Fax (907) 278-7576

The undersigned participant applies to the Trustees of the Alaska Electrical Health and Welfare Fund for the continued coverage after the maximum age defined in the Policy for the child named below who, except for age, continues to be a Dependent as defined in the Plan. This child must be incapable of self-support as the result of a developmental disability or physical handicap and must be dependent on the participant for primary support.

Participant's Name		Child's Name		
Date Participant Effective Under This Plan / /	Were Participant's Dependents Covered At That Time? ☐Yes ☐No	Child's Date of Birth / /	Was Child Covered by Prior Carrier? ☐ Yes ☐ No	If "Yes" Date Prior Coverage Ended? / /
If "No", When Was Dependent Coverage Effective?		If "Yes", Name of Prior Carrier and Phone Number		

Details About Incapacity

When Did Incapacity Start?	Was this due to injury or accident? ☐ Yes ☐ No	If so, when did it occur?
How Does Incapacity Interfere With Daily Life?		

Schools and Jobs

1. Has child been going to school or training facility since reaching age 19 (or age shown in policy)? .... ☐ Yes ☐ No
2. List schools/facilities attended: ________ Date last attended: ________
3. What education level has been reached? ________
4. This level was reached through ☐Special education program ☐Regular classes
5. Has child been working? (If answer is No, proceed to question #10) .... ☐ Yes ☐No
6. If so, where and for how long? ....
7. How many hours per week does child work? ________
8. What is the hourly wage earned? $ ________ per hour.
9. Describe the job duties. ________
10. If child has not been working, has job placement been suggested? If No, why not? ☐Yes ☐No

Other

1. Can child drive a car on his/her/own? ☐Yes ☐No
2. Does child need help in daily travel...
   - ..to school? .... ☐Yes ☐No
   - ..to work? .... ☐Yes ☐No
   - ..to activities outside the home? .... ☐ Yes ☐No
3. Does child live at home? .... ☐Yes ☐No
4. Do you regularly provide more than one-half of the financial support of this child? .... ☐Yes ☐No

   If "No," Explain: ________
5. Is this child claimed as a dependent by you for Federal Income Tax Purposes? .... ☐ Yes ☐No

   If "No," Explain: ________
6. Does child manage own money? .... ☐Yes ☐No
7. Does child have checking account? .... ☐Yes ☐No
8. If dependent child's incapacity requires residence at any place other than home address shown on back of form, give name and address of such place and amount of time spent there:

   Name of residence ________

   Address (Street) ________

   (City, State, Zip) ________

   Amount of Time Spent There ________

(over)

Statement of Participant

!,represent that to the best of my knowledge and belief all statements and answers made by me on this form, front and back, are true, complete and correct. They shall be a part of this application for continued coverage under the Plan. I agree the coverage is subject to approval by the Plan and that continued coverage is subject to written request being made within 31 days after the date the child reaches the maximum age defined in the Plan.

I authorize any doctor, health care provider, hospital, clinic, or other medically related facility who has knowledge of the child to give to the Plan any such information.

Participant's Signature________________________________ Date________________

Address (Street)________________________________City________________

State________________ Zip ________________Phone________________

Statement of Physician About Child Named on Reverse Side

The following questions should be answered about the patient's incapacity.

Date first attended patient ________________________________

Are you presently seeing patient for incapacity?________________________________

Please furnish us with the history of the incapacity. This should include diagnosis, treatment, results of special studies, present course, prognosis, etc. If the space below does not allow room for sufficient history, please attach the history to this form

In your opinion, is patient capable of self-support?________________________________

If no: How long has the incapacity existed: ________________________________

How long may such incapacity be expected to continue?________________________________

In future, is self-support possible? ________________________________

If so, when? ________________________________

Physician's Signature________________________________Date________________

Physician's Printed Name ________________________________

Address (Street)________________________________City________________

State________________ Zip________________Phone ________________

For administrative office use only:

Certified by:________________________________ Date:________________

1/11