CHRISTIAN BROTHERS SERVICES

Employee Benefit Trust
1205 Windham Parkway
Romeoville, IL 60446
800.807.9460 / 630.378.3005 fax

The undersigned employee applies to the Christian Brothers Employee Benefit Trust for continued coverage after the maximum age as defined in the Plan 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 substantial mental impairment or physical disability. Please attach proof of Legal Guardianship or Power of Attorney so that we may communicate in detail any claims or treatment while remaining compliant with HIPAA Rules.

Application For Disabled Dependent Status (To be Filled Out by the Policyholder)

Name of Policyholder

Relationship

Group Number

Account Number

Dependent's Name (Last, First, Initial)

Dependent's Birth Sex
◯ Male ◯ Female

Dependent's Birthdate (MM/DD/YYYY)

Dependent's Age When Disability Occured

Is Disability Due to Injury or Accident?
◯ Yes ◯ No

If Yes, Date of Occurance

Highest Grade Level Completed

Special Education?
◯ Yes ◯ No

Involved in a Vocational/ Work Program?
◯ Yes ◯ No

Has Job Placement Been Suggested/ Offered?
◯ Yes ◯ No

Is Dependent Currently Employed?
◯ Yes ◯ No

Employer

Hours of Work Per Day

Hours of Work Per Week

Describe Job Duties

Can Dependent Drive Self to Work?
◯ Yes ◯ No

Does Dependent Have a Drivers License?
◯ Yes ◯ No

Can Dependent Mangage Own Money?
◯ Yes ◯ No

Provide Specific Limitations and the Impact They Have on Gainful Employment

Please Give Details Regarding: Typical Day's Activity and Degree of Assistance Needed to Complete These Activities

Is Dependent Considered Disabled Under Social Security Disability Insurance (SSDI)?
◯ Yes ◯ No

Is Dependent Now Covered Under Medicare or any Other Hospital Medical Coverage?
◯ Yes ◯ No

Is Dependent Listed as a Dependent on Your Last Federal Income Tax Return?
◯ Yes ◯ No

Is This Person Dependent Upon You For Support?
◯ Yes ◯ No

If Yes, What Percentage of Support Do You Contribute?

Does Dependent Live in Your Home?
◯ Yes ◯ No (Explain)

Attending Physician Info on Next Page >

If proof of guardianship hasn't been provided to CBS, please submit it with this form.

Application For Disabled Dependent Status

To be Filled Out by the Attending Physician

Disability: ICD-10 Codes (Required)

☐ Physical _____ ☐ Behavioral _____

☐ Other (Describe)

How Long has Dependent Been Under Your Care?

Initial Date of Treatment/Care (MM/DD/YYYY)

When do You Think the Dependent Will be Able To Return to Gainful Employment?

◯ Indefinite ◯ Never ◯ Approximate Date (MM/DD/YYYY)

Is the Dependent Able to Perform the Basic Activities of Daily Living? (Independent Feeding, Dressing, Performing Personal Hygiene, and Grooming)

◯ Yes ◯ No

Does the Dependent Suffer with a Severe Organic

☐ Repeated Destructive Behavior Towards Self, Others, and/or Property.

☐ Severe Impairment of Mobility With Physical and/or Mental Inability to Use Adaptive Equipment, Such as Walkers, Crutches, Wheelchairs, etc.

☐ Chronic and/or Long-Term Disease or Injury, Impairing Ability to Work or Attend School During the Recuperative Period of the Disease or Injury.

☐ Severe or Profound Mental Retardation as Defined by Confirmed I.Q. Test Scoring. (List Below the Results of the Most Recent I.Q. Testing)

☐ Unmanageable Hallucinations, Loss of Touch with Reality, Paranoia, and/or Other Severe Dysfunctional Behaviors.

Please State Physical and Cognitive Limitations and the Impact They Have on Gainful Employment.

Name of Physician. Credentials

Physician's Signature

Date Signed (MM/DD/YYYY)

Statement of Employee

I represent that to the best of my knowledge and belief all statements and answers made on this form, front and back, are true, complete andcorrect. They shall be a part of my application for continued coverage under the Christian Brothers Employee Benefit Trust. I agree the coverage is subject to approval by The Christian Brothers Employee Benefit Trust Administrator, and that continued coverage is subject towritten request being made withing 31 days from the date that 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 dependent child to give to The Christian Brothers Services Employee Benefit Trust any such information. I also understand that any charge for this information is to be paid by me.

Employee's Signature

Date Signed (MM/DD/YYYY)

Address (Street)

City / State / Zip Code