

**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 <input type="text"/>		Relationship <input type="text"/>		
Group Number <input type="text"/>	Account Number <input type="text"/>	Dependent's Name (Last, First, Initial) <input type="text"/>		
Dependent's Birth Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Dependent's Birthdate (MM/DD/YYYY) <input type="text"/>	Dependent's Age When Disability Occured <input type="text"/>	Is Disability Due to Injury or Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Date of Occurance <input type="text"/>
Highest Grade Level Completed <input type="text"/>	Special Education? <input type="checkbox"/> Yes <input type="checkbox"/> No	Involved in a Vocational/ Work Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has Job Placement Been Suggested/ Offered? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is Dependent Currently Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer <input type="text"/>	Hours of Work Per Day <input type="text"/>	Hours of Work Per Week <input type="text"/>	
Describe Job Duties <input type="text"/>		Can Dependent Drive Self to Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does Dependent Have a Drivers License? <input type="checkbox"/> Yes <input type="checkbox"/> No	Can Dependent Mamage Own Money? <input type="checkbox"/> Yes <input type="checkbox"/> No
Provide Specific Limitations and the Impact They Have on Gainful Employment <input type="text"/>		Please Give Details Regarding: Typical Day's Activity and Degree of Assistance Needed to Complete These Activities <input type="text"/>		
Is Dependent Considered Disabled Under Social Security Disability Insurance (SSDI/SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Dependent Now Covered Under Medicare or any Other Hospital Medical Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is Dependent Listed as a Dependent on Your Last Federal Income Tax Return? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is This Person Dependent Upon You For Support? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, What Percentage of Support Do You Contribute? <input type="text"/>	
Does Dependent Live in Your Home? <input type="checkbox"/> Yes <input type="checkbox"/> No (Explain) <input type="text"/>		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

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

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

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

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

☐ 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 and correct. 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 to written request being made within 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