

# QualChoice Application for Dependant Coverage

## Disabled Child over age 19

Name of child: \_\_\_\_\_

Name of policyholder: \_\_\_\_\_

Identification number: \_\_\_\_\_

Date of enrollment with plan: \_\_\_\_\_

Birth date of child: \_\_\_\_\_

Date child's disability began: \_\_\_\_\_

Has this child been declared disabled by the Social Security Administration?

Yes. Please attach a copy of the Social Security determination letter

No

Please describe the nature of the disability

How old was your child when you first noticed that something was wrong?

Has your child been under the care of a physician?

Yes. Please provide us the name and address of the physician. Please ask that physician to complete the physician form.

No. Please make an appointment with your child's primary care physician for a complete evaluation. Please ask that physician to complete the physician form.

Has your child previously been covered either by QualChoice or by another company under a disability rider?

Yes. Which company? \_\_\_\_\_ When? \_\_\_\_\_

No.

Have you ever applied for a disability waiver for this child and been turned down?

Yes. Which company? \_\_\_\_\_ When? \_\_\_\_\_

No.

I certify that the above information is true and correct to the best of my knowledge.

\_\_\_\_\_  
Policy holder signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

Return this form to:

Care Management Department  
QualChoice/QCA  
10800 Financial Centre Parkway, Suite 540  
Little Rock, AR 72211

**QualChoice**  
**PHYSICIAN INFORMATION REGARDING DISABLED DEPENDENT**

Please complete the information below. All applicable questions must be answered in order for us to establish eligibility for disabled dependent coverage.

Employee: \_\_\_\_\_ Patient Name: \_\_\_\_\_

ID Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

What is the primary diagnosis which causes this patient to be disabled? \_\_\_\_\_  
\_\_\_\_\_

Secondary diagnosis (if applicable): \_\_\_\_\_  
\_\_\_\_\_

Please give a detailed description of the condition causing this disability. Include functional limitations (i.e. what assistance does the patient require, number of people required to assist with ADL's, etc.).  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does this condition prevent substantially gainful work? Yes \_\_\_ No \_\_\_ If yes, please explain.  
\_\_\_\_\_  
\_\_\_\_\_

Is there any type of work that this patient may be capable of performing?  
\_\_\_\_\_

What was the date of the onset for condition responsible for disability? \_\_\_\_\_

When did the patient become disabled? \_\_\_\_\_

What date did you first treat this patient for this condition? \_\_\_\_\_

What date did you last treat this patient for this condition? \_\_\_\_\_

Thank you for your time in supplying this information.

Please return form to:  
Care Management Department  
QualChoice of Arkansas, Inc.  
10800 Financial Centre Parkway, #540  
Little Rock, AR 72211

\_\_\_\_\_  
Physician Signature                      Date

\_\_\_\_\_  
Physician name and address