



Disabled Dependent Application Instructions

This Affidavit of Qualified Disabled Dependent includes the forms required to apply for continued benefits for your Disabled Dependent.

If a form is received incomplete, unsigned or undated, it will be returned to you for completion.

You must...

1. complete in full, sign and date the Insured's Statement.
2. have the physician treating your dependent complete, sign and date the Attending Physician's Statement, and have it returned to you.
3. You are responsible for ensuring all forms are completed and returned to our office **prior to** your child's 26th birthday. If you only become eligible to enroll for coverage after your child's 26th birthday, all forms must be submitted within 60 days of your enrollment. Forms can be sent to LifeMap via:

Email: claims@lifemapco.com

Fax: **1 (855) 733-4615**

Regular Mail: **LifeMap Assurance Company
Attn: Life and Disability Claims Department
200 SW Market Street, Suite 800
Portland, OR 97201**

If you have any questions, please call the LifeMap Life and Claims Department at 1 (800) 268-1129. You must notify LifeMap promptly if:

- Your disabled child's medical condition improves so that he/she will be able to work, even though they have not yet returned to work.
- He/she goes to work in any capacity for any employer, or as a self-employed person
- Your disabled child gets married or enters into a domestic partnership



Affidavit of Qualified Disabled Dependent

A dependent child who is age 26 or over may continue to be covered under your plan if they are incapable of self-support because of total disability that began before their 26th birthday. Please complete and return this form to apply for ongoing coverage for you or your Spouses dependent child.

IMPORTANT NOTE: This form must be completed and submitted to LifeMap Assurance Company prior to your child's 26th birthday. Or if you only become eligible to enroll for coverage after your child's 26th birthday, all forms must be submitted within 60 days of your enrollment

Insured's Statement

Information about Employee

| | | | |
|-------------------------------------|------|----------------------------------|----------|
| Employer/Policyholder Name | | Group Policy # | |
| Employee (Last Name, First Name MI) | | Social Security Number/Member ID | |
| Employee's Address | City | State | Zip Code |

Information about Dependent

| | | | |
|---|------|-----------------------|----------|
| Dependent (Last Name, First Name MI) | | | |
| Dependent's Relationship to Employee | | Dependent's Birthdate | |
| Dependent's Address (if not residing with Employee) | City | State | Zip Code |
| Please explain (if applicable) why dependent does not live with Employee | | | |
| Does dependent have other health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| If Yes, please provide the name of the carrier, Employee name, policy number and carrier's phone number: | | | |

I certify that _____, meets the following criteria:
name of the Totally disabled dependent (please print)

1. Is incapable of engaging in substantial gainful activity due to total disability related to physical and/or mental disability and is determined to be totally disabled prior to turning age 26; and
2. Is primarily dependent upon Employee (and/or Employee's spouse) for support and;
3. Is unmarried and not in a domestic partnership (for residents of Washington, this applies only to coverage requests for life insurance)

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice attached to this form.

Employee Signature

Date

Please have your dependent's provider complete and sign the Attending Physician's Statement

Unless specific state language is provided below, the following fraud notice applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Arizona Residents: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maryland Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Arkansas, Louisiana, New Mexico, Rhode Island and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine, Tennessee, Virginia and Washington Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Alaska and Oregon Residents: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

Delaware, Idaho, Indiana and Oklahoma Residents: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.



Affidavit of Qualified Disabled Dependent

Attending Physician's Statement

Information about Patient

| | | | |
|--|---|----------------------------|-------------------------|
| Patient's Name | | Patient's Birthdate | |
| Date patient was last examined by Provider: | Nature of condition causing incapacity: <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Medical Disability <input type="checkbox"/> Mental Disorder <input type="checkbox"/> Other (please explain) _____ | | |
| Incapacitation is: <input type="checkbox"/> Complete <input type="checkbox"/> Partial _____% incapacitated | Incapacitation is: <input type="checkbox"/> Temporary (estimated duration is) _____ <input type="checkbox"/> Permanent At what age did patient become incapacitated? _____ | | |
| Diagnosis of Condition Causing Incapacity Give as much detail as possible. Please give dates of surgery, forward laboratory data and results of special tests, such as x-rays, EKG's EEG's, etc. If mental retardation is present, give severity of retardation and IQ test score. Attach additional pages as necessary. Diagnosis: _____ _____ _____ | | | |
| Comments to Support Incapacity: _____ _____ _____ _____ | | | |
| Is patient now or will patient be capable of self-support? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? _____ | | | |
| Is patient able to perform full or part-time work of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Does the patient have a job? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, do you know what duties the patient's job requires? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain: _____ | | | |
| Provider's Name | | Specialty | Telephone Number |
| Provider's Address | City | State | Zip Code |
| | | | Fax Number |
| I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice attached to this form. | | | |
| _____ Signature of Attending Physician | | _____ Date | |

The Attending Physician's statements regarding total disability are necessary and important for LifeMap's "Totally disabled" determination; However, LifeMap is not bound by the physician's conclusion.

Insurance Fraud Notice

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New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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