TakeCare®

P.O. Box 6578 Tamuning, Guam 96931

Request for Continuation of COVERAGE OF A DISABLED CHILD

(To be completed along with an enrollment form.)

Part 1: **EMPLOYEE'S STATEMENT**

Name of Employee: _____ SSN: _____ ____ _____
Last First

Mailing Address: _____

Name of Dependent Child: _____ Date of Birth: _____ /_____ /_____

Is your child dependent upon you for support? ☐ Yes ☐ No

Child's Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced

Was your child ever employed? ☐ Yes ☐ No Is your child employed now? ☐ Yes ☐ No

If the answer is "Yes" to either questions, complete the following:

EMPLOYER	ADDRESS	DATES EMPLOYED	DESCRIPTION OF DUTIES

Summary of Any Institutional Care

NAME OF INSTITUTIONS	DATES	NATURE OF CARE

Signature of Employee Date

Signature of Employer Date Group Name

Part 2: **ATTENDING PHYSICIAN'S STATEMENT**

Note: The applicant is responsible for the completion of this form without expense to TakeCare

Is child now incapable of self-sustaining employment because of developmental delay, debilitating chronic conditions or mental/physical handicap? ☐ Yes ☐ No

Did such incapacity exist prior to child's attainment of age 19? ☐ Yes ☐ No

May child be employable in the future? ☐ Yes ☐ No ☐ Questionable

Nature & Cause of incapacity: _____

Date of Onset: Prognosis

Please indicate results of any intelligence test & exam findings:

Current treatment/medication: _____

Will child require future care? ☐ Yes ☐ No

Name of Primary Medical Provider

Address

Primary Medical Provider's Signature Date