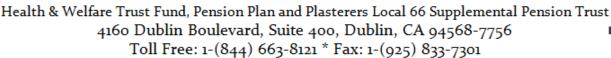
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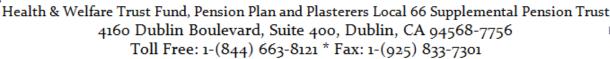


Email: plasterersinfo@hsba.com

REQUEST FOR CONTINUED COVERAGE FOR INCAPACITATED CHILD

TO BE COMPLETED BY ATTENDING PHYSICIAN									
Note: Any fee for the completion of this form is the responsibility of the employee.									
PATIENT'S NAME		DATE OF BIRTH							
DIAGNOSIS (BE AS DETAILED AS POSSIBLE)									
Birtollogic (BE / to BE / riezes / to 1 GoodBEE)									
		☐ MILD ☐ MODERATE ☐ SEVERE							
TOPATHENE									
TREATMENT DATE OF FIRST TREATMENT	WHEN DID YOU LAST TREAT PATIENT?								
DATE OF THE THE ATMENT	WILNERSTONE	LATTATIENT:							
LIST OF MEDICATIONS TAKEN FOR DISABLING CONDITION									
Submit clinical summary and/or current supporting documentation of disabling condition. For mental conditions, include current IQ test results if									
available. EXTENT OF DISABILITY									
IS PATIENT NOW INCAPABLE OF SELF-SUPPORT BECAUSE OF A DISABILITY?									
INDICATE CURRENT FUNCTIONAL CAPABILITIES AND LIMITATIONS									
HAS SUCH DISABILITY EXISTED CONTINUOUSLY SINCE BEFORE THE PATIENT ATTAINED AGE 19?									
☐ YES ☐ NO									
DO YOU THINK PATIENT WILL BE ABLE TO RETURN TO GAINFUL EMP	LOYMENT?								
☐ YES, INDICATE APPROXIMATE DATE:	□ INDEFINITE	☐ NEVER							
PHYSICIAN NAME		PHYSICIAN PHONE							
PHYSICIAN ADDRESS	CITY		STATE	ZIP					
For your protection, California law requires the following to appear on this form: Any person who knowingly presents a 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.									
ciaim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.									
Signature of Physician			ate						
INTERNAL OFFICE USE ONLY									

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REQUEST FOR CONTINUED COVERAGE FOR INCAPACITATED CHILD

TO BE COMPLETED BY COVERED EN	MPLOYEE							
EMPLOYEE'S NAME	YEE'S NAME SOCIAL SECURITY NUMBER			DATE OF BIRTH				
						T		
HOME ADDRESS		CITY			STATE	ZIP		
GROUP NAME					TELEPHON	 E NUMBER		
EMPLOYER			DATE OF HIRE					
INFORMATION ABOUT INCAPACITATED CHILD								
				RELATI	IONSHIP TO EMPLOYEE			
DATE OF BIRTH	CHILD'S AGE WHEN DISABILITY OCCURRED							
	☐ MALE ☐ FEMALE							
DESCRIBE DISABILITY								
			IF YES, PLEASE INDIC	ATE PER	CENTAGE SU	PPORT:		
IS CHILD DEPENDENT ON YOU FOR SUPPORT	? \(\text{YES} \(\text{NO} \)							
IS CHILD LISTED AS A DEPENDENT ON YOUR LAST FEDERAL INCOME TAX RETURN? IF NO, PLEASE INDICATE WHY NOT: YES NO								
II NO, I LEAGE INDICATE WITH NOT.								
IS CHILD PERMANENTLY RESIDING IN YOUR HOUSEHOLD?			☐ YES ☐ NO					
IF NO, PLEASE INDICATE WHY NOT:								
IS THIS DEPENDENT CURRENTLY A FULL-TIM	E STUDENT?			□ Y	′ES □ N	0		
NAME OF SCHOOL HOURS ATTENDED DAILY				AILY				
			1					
IS CHILD RECEIVING SOCIAL SECURITY DISABILITY INCOME?		□ Y	ES N	0				
IS CHILD COVERED UNDER ANY OTHER HOSPITAL OR MEDICAL COVERAGE?			□ Y	′ES □ N				
IF YES, PLEASE GIVE NAMES OF INSURANCE COMPANIES AND POLICY NUMBERS								
For your protection, California law requires the following to appear on this form: Any person who knowingly presents a 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.								
Signature of Employee			Date					
INTERNAL OFFICE USE ONLY								
	INTERNAL OF	FICE US	DE UNLY					