Northern California Plasterers Trust Funds

Health and Welfare Trust Fund, Pension Plan, and Plasterers Supplemental Pension Trust
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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)	☐ MILD ☐ MODERATE ☐ SEVERE

TREATMENT

DATE OF FIRST TREATMENT	WHEN DID YOU LAST TREAT PATIENT?

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? ☐ YES ☐ NO

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 EMPLOYMENT?

☐ 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.

Signature of Physician _____ Date _____

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REQUEST FOR CONTINUED COVERAGE FOR INCAPACITATED CHILD

TO BE COMPLETED BY COVERED EMPLOYEE

EMPLOYEE'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	
HOME ADDRESS	CITY	STATE	ZIP
GROUP NAME		TELEPHONE NUMBER	
EMPLOYER		DATE OF HIRE	

INFORMATION ABOUT INCAPACITATED CHILD

CHILD'S NAME		RELATIONSHIP TO EMPLOYEE
DATE OF BIRTH	☐ MALE ☐ FEMALE	CHILD'S AGE WHEN DISABILITY OCCURRED

DESCRIBE DISABILITY

IS CHILD DEPENDENT ON YOU FOR SUPPORT? ☐ YES ☐ NO	IF YES, PLEASE INDICATE PERCENTAGE SUPPORT:

IS CHILD LISTED AS A DEPENDENT ON YOUR LAST FEDERAL INCOME TAX RETURN? ☐ YES ☐ NO

IF NO, PLEASE INDICATE WHY NOT:

IS CHILD PERMANENTLY RESIDING IN YOUR HOUSEHOLD? ☐ YES ☐ NO

IF NO, PLEASE INDICATE WHY NOT:

IS THIS DEPENDENT CURRENTLY A FULL-TIME STUDENT? ☐ YES ☐ NO

NAME OF SCHOOL	HOURS ATTENDED DAILY

IS CHILD RECEIVING SOCIAL SECURITY DISABILITY INCOME? ☐ YES ☐ NO

IS CHILD COVERED UNDER ANY OTHER HOSPITAL OR MEDICAL COVERAGE? ☐ YES ☐ NO

IF YES, PLEASE GIVE NAMES OF INSURANCE COMPANIES AND POLICY NUMBERS

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Signature of Employee

Date

INTERNAL OFFICE USE ONLY

REV 2017