

Continuation of Group Insurance for Handicap Dependent Child

For Continuation of Group Insurance for the Dependent Child
due to Mental or Physical handicap.

Metropolitan Life Insurance Company

Things to know before you begin

- **All sections (*Plan Administrator, Member and Physician*) are REQUIRED.**
- **Note:** Children who exceed the age limit prior to sustaining a mental or physical handicap are not eligible for coverage, nor are children who were not insured under the MetLife Group Policy prior to attainment of the plan's age limit, regardless of handicap status.



**Answer all questions.
Omitted information will
cause delays.**

SECTION 1: How to submit this form

Make a copy for your records & FAX or MAIL completed forms to:

Mail:

MetLife SOH Unit
PO Box 14069
Lexington, KY 40512-4069

Fax:

MetLife SOH Unit
1-859-225-7909

We're here to help

For inquiries, contact 1-800-638-6420, Prompt 1 (*Statement of Health Unit*) or email
OADEligibility@metlife.com

SECTION 2: Plan Administrator's statement - REQUIRED

To be Completed by Authorized Customer Representative.

Member - First name	Middle name	Last name
Social Security/ID number	What Dependent coverage is this form being submitted for? ☐ Dental	
Plan Administrator name		Group number

Authorized Plan Administrator signature	Title	Date (mm/dd/yyyy)
---	-------	-------------------

SECTION 3: Member's statement

First request: ☐ Yes ☐ No | Prior request date (mm/dd/yyyy) _____

► Member information

First name	Middle name	Last name		
Address		City	State ▼	ZIP
Social Security number	Date of birth (mm/dd/yyyy)	☐ Male ☐ Female	Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Phone number

► Dependent information

First name	Middle name	Last name		
Address		City	State ▼	ZIP
Social Security number	Date of birth (mm/dd/yyyy)	☐ Male ☐ Female	Age	Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Relationship to member	Current Customer Name			
Customer address		City	State ▼	ZIP
If not now employed, give date last employed: Date (mm/dd/yyyy)	Estimated income of Dependent from all sources monthly	Percentage of support of Dependent supplied by Member %		

Is the Dependent permanently residing in Member's household? ☐ Yes ☐ No

If No, explain:

Member Certifications and signature

By signing below, I acknowledge:

1. All information I have given is true and complete to the best of my knowledge and belief.
2. Group insurance may be continued past the plan's age limit if the covered child is incapable of self-sustaining employment because of a mental or physical handicap. Proof of such handicap must be provided to MetLife within 31 days after the date the child attains the age limit. **Children who exceed the age limit prior to sustaining a mental or physical handicap are not eligible for coverage, nor are children who were not insured under the MetLife Group Policy prior to attainment of the plan's age limit, regardless of handicap status.**
3. I have read the applicable Fraud Warning(s) provided in this form.

Member signature

Date (mm/dd/yyyy)

SECTION 4: Physician's/Surgeon's statement *(Any fee for completion of this statement is to be paid by the Member.)*

► **Patient's/Dependent's information.** *(pertaining to the handicap dependent)*

Date of birth (mm/dd/yyyy) _____

First name	Middle name	Last name
_____	_____	_____

Is this Dependent presently incapable of self-sustaining employment by reason of:

Physical handicap? Mental handicap? Other (*explain*)

☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

If "other," explain: _____

Date Dependent became incapable of self-sustaining employment _____ Date (mm/dd/yyyy)

Diagnosis of condition causing incapacity. Give as much detail as possible. Please give date and report of surgery, X-rays, electrocardiograms, or other special tests. Use separate sheet of paper if necessary.

Functional age level	Does the patient have a job? ☐ Yes ☐ No	Do you know what the patient's job is? ☐ Yes ☐ No	Do you know what duties the patient's job requires? ☐ Yes ☐ No
_____	_____	_____	_____

Has this patient been able to do full or part-time work of any kind?

☐ No ☐ Yes from _____ Date (mm/dd/yyyy)

Will the patient be capable of self-support?

If No, provide an explanation on a separate sheet of paper.

☐ No ☐ Yes from _____ Date (mm/dd/yyyy)

The patient is presently (*check one*) ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

Physician's/Surgeon's signature

Physician's information

First name	Middle name	Last name
_____	_____	_____

Address	City	State	ZIP
_____	_____		_____

Physician's/Surgeon's signature

Phone number	Date (mm/dd/yyyy)
_____	_____

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the 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 may have violated the state law.

New York (*only applies to Accident and Health Benefits*): 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 shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**CALIFORNIA HEALTHCARE LANGUAGE ASSISTANCE PROGRAM
NOTICE TO INSURED**

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, if any, or 1-800-942-0854. For more help call the CA Dept. of Insurance at 1-800-927-4357.

To receive a copy of the attached MetLife document translated into Spanish or Chinese, please mark the box by the requested language statement below, and mail the document with this form to:

Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512

Please indicate to whom and where the translated document is to be sent.

- ☐ **Servicio de Idiomas Sin Costo.** Puede obtener la ayuda de un intérprete. Se le pueden leer documentos y enviar algunos en español. Para recibir ayuda, llámenos al número que aparece en su tarjeta de identificación, si tiene una, o al 1-800-942-0854. Para recibir ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357.

Para recibir una copia del documento adjunto de MetLife traducido al español, marque la casilla correspondiente a esta oración, y envíe por correo el documento junto con este formulario a:

Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512

Por favor, indique a quién y a dónde debe enviarse el documento traducido.

NOMBRE _____

DIRECCIÓN _____

- ☐ **免費語言服務。** 您可獲得免費口譯服務。您可要求翻譯員向你口譯文件，或可要求向你發回文件的中文譯本。如需協助，請致電您的ID卡上所示號碼（如有），或 1-800-942-0854。如需更多協助，請致電加州保險部熱線 1-800-927-4357。

為收取隨附MetLife文件的中文譯本，請勾選此陳述前的方框，並將文件連同此表一併郵寄至：

Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512

請指明經翻譯文件收件人的姓名及地址。

姓名 _____

地址 _____

Անվճար թարգմանչապան ծառայություններ: Ձեզ կտրամադրվի հայերենի թարգմանիչ, որի օգնությամբ կարող եք հայերենով կարդալ փաստաթղթերը: Հարցերի դեպքում զանգահարեք մեզ Ձեր ID քարտի վրա նշված հեռախոսահամարով կամ 1-800-942-0854: Առավել մանրամասն տեղեկատվության համար զանգահարեք Կալիֆոռնիայի Ապահովագրական Դեպարտամենտ 1-800-927-4357 հեռախոսահամարով:

សេវាកម្មប្រែដោយឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែម្នាក់ និងឱ្យគេអានឯកសារនានាឱ្យអ្នកស្តាប់ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែលមានចុះនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នកប្រសិនបើមាន ឬ តាមលេខ 1-800-942-0854 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងនៃរដ្ឋកាលីហ្វ័រញ៉ា (CA Dept. of Insurance) តាមលេខ 1-800-927-4357 ។

Kev pab txhais lus tsis kom them nqi. Koj thov tau kom nrhiav neeg txhais lus thiab nyeem ntaub ntawv hais ua lus Hmoob rau koj mloog. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj sau hauv koj daim npav ID, yog muaj, lossis 1-800-942-0854. Yog xav kom pab lwm yam hu rau lub CA Hauv Paus Iv-saws-las ntawm 1-800-927-4357.

無料の通訳サービス。 通訳を通して日本語で文書を読み上げてもらうことができます。サービスの利用をご希望の方は、お手持ちのIDカードに記載されている番号、または 1-800-942-0854 へお電話ください。さらなる支援が必要な場合は、カリフォルニア州保険庁 1-800-927-4357 までお問い合わせください。

무료 통역 서비스. 통역자가 문서를 한국어로 읽어드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 있는 번호나 1-800-942-0854 로 전화하십시오. 다른 도움이 필요하시면, 전화번호 1-800-927-4357 로 캘리포니아 보험국에 연락하여 주십시오.

Бесплатные услуги устного перевода. Вы можете воспользоваться услугами переводчика, который прочитает вам документы на русском языке. Чтобы получить помощь, позвоните нам по номеру, указанному на вашей идентификационной карточке, если у вас она есть, либо по номеру 1-800-942-0854. Если вам нужна помощь в других вопросах, позвоните в горячую линию Департамента страхования (CA Dept. of Insurance) 1-800-927-4357.

Libreng serbisyo sa pagsasalin. Maaari kang kumuha ng tagasalin para basahin sa iyo ang mga dokumento sa wikang Tagalog. Para ikaw ay matulungan, tawagan kami sa numerong nakalista sa iyong ID card, kung mayroon man, o sa numerong 1-800-942-0854. Para sa karagdagang tulong tawagan ang CA Dept. of Insurance sa numerong 1-800-927-4357.

Dịch vụ thông dịch miễn phí. Quý vị có thể tìm một thông dịch viên và nhờ đọc các tài liệu này cho quý vị bằng tiếng Việt. Để được giúp đỡ, gọi cho chúng tôi tại số nêu trên thẻ ID của quý vị, nếu có, hoặc 1-800-942-0854. Để được giúp đỡ thêm gọi cho Ban Bảo Hiểm CA tại số 1-800-927-4357.

لا تتوفر خدمات ترجمة بتكلفة. يمكنك الاتصال بمترجم والحصول على خدمة قراءة المستندات باللغة العربية. للمساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك، أو اتصل بالرقم 1-800-942-0854. ولمزيد من المساعدة، اتصل بقسم التأمينات التابع لـ CA على الرقم 1-800-927-4357.

سرویس های ترجمه رایگان. شما می توانید مترجم و اسنادی را به زبان فارسی برای مطالعه دریافت کنید. برای راهنمایی، از طریق شماره درج شده در کارت شناسایی خود (در صورت وجود) یا شماره 1-800-942-0854 با ما تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه کالیفرنیا 1-800-927-4357 تماس بگیرید.

بلا معاوضه مترجم دی خدمات مل سکدی اے۔ تسی ایک مترجم دی خدمات حاصل کرسکدے او جو توڈے واسطے دستاویزات پنجابی وچ پڈ سکدا اے۔ مدد واسطے ایڑیں آئی ڈی کارڈ، گروپو، توڈے وچ نمبر یا 1-800-942-0854 پہ کال کرو۔ آگے مزید مدد واسطے اے نمبر 1-800-927-4357 پہ سی اے ڈیپارٹمنٹ برائے انشورنس نال گال کرو۔