PLEASE RETURN FORM TO:

BENEFIT PLAN ADMINISTRATORS
PO BOX 1128
EAU CLAIRE, WI 54702-1128

PROOF OF INCAPACITATED CHILD

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME (first, middle, last)			SOCIAL SECURITY NUMBER
HOME ADDRESS			TELEPHONE NUMER
EMPLOYER NAME			GROUP NUMER
INCAPACITED CHILD'S NAME	SEX	BIRTHDATE	MARITAL STATUS

CHILD'S AGE WHEN DISABILITY OCCURRED

DESCRIBE CHILD'S DISABILITY

IS CHILD DEPENDENT ON YOU FOR SUPPORT?

_______YES _____NO IF YES, WHAT PERCENT _________%

IS CHILD LISTED AS YOUR DEPENDENT ON YOUR LAST FEDERAL TAX RETURN?

_______YES _____NO IF YES, WHAT TAX YEAR _________

IS CHILD A PERMANENT RESIDENT IN YOUR HOUSEHOLD? ____YES ____NO

IF NO, WHY NOT? ____

IS CHILD COVERED UNDER ANY OTHER HOSPITAL OR MEDICAL COVERAGE? ____YES ____NO

IF YES, GIVE NAMES OF INSURANCE COMPANIES AND POLICY NUMBERS: ____
____

IS CHILD RECEIVING ANY TYPE OF GOVERNMENT ASSISTANCE? ____YES ____NO

IF YES, INDICATE TYPE OF ASSISTANCE: ____

IMPORTANT: ATTACH ATTENDING PHYSICIAN'S STATEMENT PROVIDING DETERMINATION OF INCAPACITY.

I certify that the above information is true and correct. I hereby authorize all doctors, hospitals, pharmacies or other institutions rendering care and treatment to furnish Benefit Plan Administrators with full information regarding treatment rendered (including copies of their records). I also authorize any employer or insurance company to furnish Benefit Plan Administrators with information regarding benefits to which I or my dependents may be entitled. A copy or photocopy of this authorization shall be considered as effective and valid as the original.

ALSO, I HEREBY UNDERSTAND THAT BENEFIT PLAN ADMINISTRATORS MAY REQUEST PROOF OF THE INCAPACITATION OF THE ABOVE NAMED CHILD AS OFTEN AS NECESSARY, AND THAT THE PLAN IS IN NO WAY WAIVING ITS RIGHT TO DECLINE CONTINUANCE OF COVERAGE IF, IN ITS OPINION, THE INCAPACITATION DOES NOT FULFILL THE NECESSARY REQUIREMENTS.

Employee Signature **Date**