TEAMCARE®
A CENTRAL STATES HEALTH PLAN

APPLICATION FOR EXTENSION OF COVERAGE

FORM MUST BE COMPLETED IN FULL BEFORE PAYMENT IS CONSIDERED

Remit To: TeamCare, PO Box 5107 Des Plaines IL 60017-5107 or Fax Form To: 847-518-9757

PARTICIPANT'S INFORMATION **PLEASE PRINT**

Participant's Identification Number:	Participant's Full Name:
8 0 6	

Participant's Complete Address:

Applicant's Name: (if other than Participant)	Applicant's Date of Birth:

THE EXTENSION OF COVERAGE IS ONLY AVAILABLE IF CERTAIN CRITERIA IS MET. IF APPROVED, BENEFITS ARE ONLY FOR THE PERSON WHO IS TOTALLY DISABLED AND COVERS ONLY THE SPECIFIC MEDICAL CONDITION THAT HAS TOTALLY DISABLED HIM OR HER. ANOTHER OPTION THAT MAY BE AVAILABLE FOR CONTINUED COVERAGE IS COBRA SELF-PAYMENTS. A COBRA NOTICE HAS BEEN OR WILL BE SENT REGARDING ELIGIBILITY TO MAKE COBRA SELF-PAYMENTS.

****** PLEASE BE SURE TO HAVE PAGE 2 COMPLETED BY YOUR PHYSICIAN ******

SECTIONS 1, 2, 3 and 4 TO BE COMPLETED IN FULL BY THE PARTICIPANT

1. Is your spouse employed? ☐ Yes ☐ No If yes, please complete the following:

   Employer's Name: _____ Name of Insurance Carrier: _____

2. IF YOUR SPOUSE HAS NO INSURANCE COVERAGE THROUGH HIS OR HER EMPLOYER OR IF THE APPLICANT IS NOT COVERED UNDER THE ABOVE NAMED INSURANCE, A LETTER IS REQUIRED FROM THE EMPLOYER VERIFYING NO INSURANCE COVERAGE AND THE REASON FOR NO COVERAGE.

   I have attached a letter from my spouse's employer verifying the applicant is not covered under insurance through my spouse:

   ☐ Yes ☐ No

3. Is the applicant covered under Medicare or any other medical insurance plan? ☐ Yes ☐ No

   If yes, please complete the following:

   Name of insurance carrier: _____ Date coverage began: _____

4. Has the applicant applied for a Social Security Disability Award? ☐ Yes ☐ No

   If yes, please check the status of the award: ☐ APPROVED ☐ STILL UNDER REVIEW ☐ DENIED ☐ UNDER APPEAL

PLEASE SEND A COPY OF ALL DOCUMENTS THAT APPLY TO YOUR SOCIAL SECURITY APPLICATION, INCLUDING A MEDICARE CARD.

I CERTIFY THAT ALL OF THESE STATEMENTS ARE TRUE AND CORRECT: _____
Participant's Signature

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PLEASE HAVE YOUR PHYSICIAN COMPLETE THIS FORM IN FULL

IN ORDER TO PROCESS OUR PARTICIPANT'S REQUEST FOR AN EXTENSION OF BENEFITS, WE NEED A CURRENT STATEMENT FROM HIS OR HER PHYSICIAN REGARDING THE EXTENT AND DEGREE OF THE DISABLING CONDITION.

Patient 's Name:	Patient's Date of Birth:

1. Disabling Diagnosis: _____ ICD.9 CODE: _____
2. Is the patient disabled from work? ☐ Yes ☐ No
3. Is the patient disabled from normal daily activities? ☐ Yes ☐ No
4. What is the extent/degree of the disability? _____

   _____

   Prognosis? _____
5. What is the anticipated duration of the disability and the treatment plan? Please attach the treatment plan if necessary.

   _____

   _____

   _____

   _____

Physician's Signature: _____ Printed Name: _____

Physician's Phone Number: _____ Date Form Completed: _____