# Request for Continuation of Life Coverage for Incapacitated Children

## GuideStone Financial Resources

Reset Form

**PART I: EMPLOYER'S STATEMENT**

Effective date of employee's coverage: _____/_____/ _____

Effective date of employee's dependent coverage for this dependent: _____/_____/_____

Has coverage been continuously in effect up to the present date for employee? ☐ No ☐ Yes If "No," explain:

_____

For dependent? ☐ No ☐ Yes If "No," explain:

_____

Has this child's coverage been continued beyond the limiting age by any previous insurer? ☐ No ☐ Yes If "Yes," please provide copy of your carrier's approval notice. Prior carrier's extension of benefits provision ended/ends (date): _____/ _____/ _____

Employer name (print): _____

Employer address: _____

Employer's authorized representative: _____ Date: _____/_____/_____

Title: _____ Telephone number: (_____) _____

**PART II: EMPLOYEE'S STATEMENT**

Employee last name (print): _____ First: _____ MI: _____

Employee Social Security number (last four digits): _____

Street address: _____

City: _____ State: _____ ZIP Code: _____

Name of dependent child (print): _____ Child's birth date: _____/_____/_____

Is child dependent upon you for support? ☐ No ☐ Yes If "Yes," what part of support do you contribute? _____

Has child been employed since reaching limiting age for dependents? ☐ No ☐ Yes (Limiting age of 26)

If "Yes," give name(s) and address(es) of employer(s), dates employed and earnings:

_____

Summary of any institutional care:

| **Name(s) of institution(s)** | **Dates** | **Nature of care** |
|---|---|---|
| _____ | _____/_____/_____ | _____ |
| _____ | _____/_____/_____ | _____ |

Employee signature: _____ Date: _____/_____/_____

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## PART III: ATTENDING PHYSICIAN'S STATEMENT

**Any expenses associated with the completion of this section will be the responsibility of the applicant.**

Is child now incapable of self-sustaining employment because of mental or physical handicap? ☐ No ☐ Yes

Did such incapacity exist prior to child's attainment of age 26? ☐ No ☐ Yes

If "No," when did incapacity first exist? _____

May child be employable in future? ☐ No ☐ Yes ☐ Questionable

Nature and cause of incapacity. Please furnish complete diagnosis. You may attach a narrative relative to the diagnosis/prognosis:

_____

Date of onset: _____/_____/_____ Date child was last examined: _____/_____/_____ Prognosis: _____

How condition restricts child's ability to engage in normal activities: _____

Physician name (print): _____ Degree: _____

Physician signature: _____ Date: _____/_____/_____

Street address: _____

City: _____ State: _____ ZIP Code: _____

**If an employee has a mentally or physically handicapped child who, under the terms of the plan, qualifies for the continuation of coverage after the plan's limiting age, this form should be completed and submitted to GuideStone by you or the employer within 31 days following the attainment of the limiting age.**

If you have any questions, call **1-888-98-GUIDE** (1-888-984-8433) to speak with a customer relations specialist.

**Return completed form to:** GuideStone
Insurance Services
5005 LBJ Freeway, Ste. 2200
Dallas, TX 75244-6152

**Completed form may be faxed to:** 1-877-834-1025