Edificio **MAPFRE**
Urb. Tres Monjitas Industrial
297 Ave. Carlos Chardón, **San Juan** PR 00918-1410

PO Box 70297, **San Juan** PR 00936-8297

**T** 787.250.5214 **T** 1.888.835.3634 **F** 787.622.7775 **W** www.mapfrepr.com

MAPFRE | SALUD

# APPLICATION CONTINUANCE OF HANDICAPPED CHILD

According to the provisions of your group policy, persons with handicapped, covered dependents child may arrange for this child's continued coverage under the policy if the child is incapable of sustaining gainful employment because of mental or physical handicap. This continued coverage would be in force for as long as your policy remains in force, the employee's dependent insurance remains in force and the dependent child remains handicapped, unmarried and dependent upon the insured for principal support. **Proof of continued dependency due to a handicap may be required annually. THIS PROVISION IS NOT AUTOMATIC.** A formal request for continuation of insurance should be made at least thirty-one days prior to the date the dependent's insurance would otherwise terminate.

| **Employer's Statement** | | | |
|---|---|---|---|
| **Name** | | **Policy Number** | |
| **Address** | | | |
| **Employee** | | | |
| **Name** | | **Date of Employment (m/d/y)** | |
| **Address** | | | |
| **Effective Date of (m/d/y):** | **Employee's Insurance** | | **Dependent's Insurance** |
| | | | |
| **Authorized Signature** | | | **Date (m/d/y)** |

| **Employee's Statement** | |
|---|---|
| I request than in consideration of the payment of appropriate premiums for dependent coverage, MAPFRE Life continue Major Medical insurance coverage for _____, my handicapped, unmarried dependent child whose date of birth is (d/m/y) _____My child is mentally and/or physically incapable of self-sustaining employment and is completely dependent upon me for principal support and maintenance. | |
| | |
| **Address** | **Employee Signature** |

| **Physician's Statement** |
|---|
| I certify that (Name of Patient) _____ is incapable of self – sustaining employment because of (Nature of Illness or Injury)_____ which commenced at or about _____ years of age in the year _____. |
| **History** |
| |
| **Present Condition** |
| |
| **Subjective Symptoms** |
| |

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| **Objective Findings** | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| **Diagnostic** | | **Treatment** | | | |
| **Date of First Visit (m/d/y)** | | **Date of Most Recent Visit (m/d/y)** | | **Frequency of visits** | |
| **Type and quantity of work patient is capable of (If any)** | | | | | |
| **Prognosis** | | | | | |
| | | | | | |

## FRAUD WARNING

Any person who knowingly and with the intention to commit fraud provides false information in an insurance application, or submits, helps or causes the submission of a fraudulent insurance claim for the payment of a loss or any other benefit, or submits more than one claim for the same damage or loss, will incur in a felony and, upon conviction thereof, shall be punished, for each violation, with a fine not less than five thousand (5,000) dollars, not greater than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravating circumstances are present, the fixed penalty established could be increased up to a maximum of five (5) years; if attenuating circumstances are present, the penalty could be reduced to a minimum of two (2) years.

| | | |
|---|---|---|
| | | |
| **Signature** | **Print Name** | **Date (m/d/y)** |

**Rev. 04/04**