THE CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST
APPLICATION FOR DEPENDENT HANDICAP STATUS

The undersigned employee applies to the Christian Brothers Employee Benefit Trust for continued coverage after the maximum age as defined in the Plan for the child named below who except for age continues to be a dependent as defined in the Plan. This child must be incapable of self-support as the result of substantial mental impairment or physical handicap.

Name of Location:			Location #:
Member's Name:	Effective date in Plan:	Were dependents covered at that time? ❍ Yes ❍ No	If not, when was dependent coverage effective?
Child's Name:			Date of Birth:

DETAILS ABOUT INCAPACITY

When did incapacity start?	Was this due to injury or accident? ❍ Yes ❍ No	If so, when did it occur?
Incapacity is due to: ❍ Mental impairment ❍ Physical ❍ Other (describe):	How does incapacity interfere with daily life?	

SCHOOLS AND JOBS

1. Has child been going to school or training facility since reaching age 19 (or age shown in Plan)? ❍ Yes ❍ No
2. List schools/facilities attended: Date last attended:

   _____ _____

   _____ _____

   _____ _____
3. What education level has been reached? _____

   _____
4. This level was reached through:
   ❍ **Special education program** ❍ **Regular classes**
5. Has child been working? ❍ Yes ❍ No
6. If so, where and how long? _____
7. How many hours per week does the child work? _____
8. What is the hourly wage earned? $_____ per hour.
9. Describe the job duties: _____

   _____

   _____
10. If the child has not been working, has job placement been suggested? ❍ Yes ❍ No

OTHER

1. Can child drive a car on his/her own? ❍ Yes ❍ No
2. Does child need help in daily travel... ❍ Yes ❍ No
   ...to school? ❍ Yes ❍ No
   ...to work? ❍ Yes ❍ No
   ...to activities outside the home? ❍ Yes ❍ No
3. Name and address of the doctor:

   Name _____

   Address _____

   City/ST/Zip _____
4. Does child manage own money? ❍ Yes ❍ No
5. Does child have checking account? ❍ Yes ❍ No
6. If dependent child's incapacity requires residence at any place other than home address shown on the back of the form, give name and address of such place and amount of time spent there:

   Name of Residence _____

   Address _____

   City/ST/Zip _____

   Amount of time spent there: _____

FINANCIAL SUPPORT

1. What percentage of financial support and maintenance do you provide for this child?

   _____

   _____

   _____
2. Please list any and all other sources of financial support for this child and the percentage(s) provided:

   _____

   _____

   _____

NOTE: THE INFORMATION ON THE BACK OF THIS APPLICATION MUST BE FILLED OUT BY THE MEMBER AND THE DEPENDENT CHILD'S DOCTOR.

STATEMENT OF EMPLOYEE

I represent that to the best of my knowledge and belief all statements and answers made on this form, front and back, are true, complete and correct. They shall be a part of my application for continued coverage under the Christian Brothers Employee Benefit Trust. I agree the coverage is subject to approval by The Christian Brothers Employee Benefit Trust Administrator, and that continued coverage is subject to written request being made withing 31 days from the date that the child reaches the maximum age defined in the Plan.

I authorize any doctor, health care provider, hospital, clinic, or other medically related facility who has knowledge of the dependent child to give to The Christian Brothers Services Employee Benefit Trust any such information. I also understand that any charge for this information is to be paid by me.

Employee's Signature: _____ Date: _____

Address (Street) _____

(City/ST/Zip) _____

STATEMENT OF DOCTOR ABOUT CHILD NAMED ON REVERSE SIDE

The following questions should be answered about the incapacity:

Date first attended patient: _____

Are you presently seeing patient for incapacity? _____

Please furnish us with history of the incapacity. This should include diagnosis, treatment, results of special studies, present course, prognosis, etc.

In your opinion, is patient capable of self-support? _____

If no: How long has incapacity existed? _____

How long may such incapacity be expected to continue? _____

In future, is self-support possible? _____

If so, when? _____

Physician's signature _____ Date _____

Address (Street) _____

(City/ST/ZIP) _____