Individual Assurance Company (FSM), Inc. **Child with Disability Eligibility Form**
(herein called IAC)

Instructions

1. This Form must be submitted within 31 days of the first of the following to occur: (a) becoming eligible for insurance or (b) termination of insurance due to the maximum age limit for dependent children as provided under your plan.
2. Upon completion of this Form by the Employee and Employer, forward the Form to the attending physician for completion of the Attending Physician Statement.
3. Return the fully completed Form to:
   Individual Assurance Company (FSM), Inc.
   c/o Individual Assurance Company, Administrator
   ATTN: FSM Group Underwriting
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   Edmond, OK 7300п

   Complete this Form in its entirety.
   Incomplete forms cannot be processed
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4. IAC will notify the Employer whether coverage is approved.

Employee's Information:

Name (last, first, middle initial):_____ Date of Birth: _____

Mailing Address:_____ Social Security #:_____

Government Agency/Department: _____ Date of Hire: _____

Dependent's Information:

Name (last, first, middle initial):_____

Social Security Number: _____ Date of Birth: _____

Relationship:_____ Last date Dependent attended school full time:_____

Employee's Statement:

I certify that the above named Dependent (1) is my unmarried child; (2) is mentally or physically incapable of earning his/her own living; (3) became incapable prior to the limiting age for dependent coverage under the group master policy; and (4) is primarily dependent upon me for support and maintenance.

The nature of the disability is_____

_____ , and the disability commenced on the following date: _____ .

With respect to the Dependent listed above, I hereby request insurance which would (1) otherwise not be available due to the Dependent exceeding the limiting age for dependent children or (2) otherwise terminate due to the Dependent attaining the limiting age. I understand that on the part of IAC, no liability for claim exists with respect to any period of time prior to the receipt and approval of this Form by IAC or its representatives. IAC is authorized to contact the Dependent's attending physician to obtain necessary information concerning the Dependent's incapacity.

_____ Witness: _____

Signature of Employee Date Signature of Employer Date

Attending Physician's Statement:

Any expense associated with the completion of this section will be the responsibility of the Employee. Copies of medical records/reports to substantiate diagnosis and prognosis must accompany this Form.

Diagnosis/Concurrent Condition:_____

Date Diagnosed: _____ Prognosis:_____

Physician Name: _____ Signature:_____

Degree _____ Telephone #: _____

Address (Street, City, State & Zip Code) _____

For Home Office Use Only ☐ Coverage Approved. ☐ Coverage Declined. By:_____ Date: _____
Follow-up Recommendation: ☐ Frequent (condition expected to change) ☐ Infrequent

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud which is a crime and subject such person to criminal and civil penalties.