

REQUEST FOR CONTINUATION OF LIFE COVERAGE FOR INCAPACITATED CHILDREN GUIDESTONE FINANCIAL RESOURCES

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 number: _____

Employer Address: _____

City: _____ State: _____ ZIP code: _____

Employer's Authorized Representative signature: _____ Date: _____

Title: _____ Telephone: _____

PART II: EMPLOYEE'S STATEMENT

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

Social Security number (last four digits): _____

Address: _____

City: _____ State: _____ ZIP code: _____

Name of dependent child (print): _____ Child's birthdate: _____

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: _____

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 **1-844-467-4843** to speak with a Customer Solutions 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

Or email to: *Insurance@GuideStone.org*