



**REQUEST FOR CONTINUED COVERAGE  
FOR INCAPACITATED CHILD  
SIGN PICTORIAL & DISPLAY INDUSTRY  
WELFARE FUND**

P.O. Box 2500  
San Francisco, CA 94126  
415/986-6276

**TO BE COMPLETED BY ATTENDING PHYSICIAN**

Note: Any fee for the completion of this form is the responsibility of the employee.

PATIENT'S NAME	DATE OF BIRTH
DIAGNOSIS (BE AS DETAILED AS POSSIBLE)	<input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE

**TREATMENT**

DATE OF FIRST TREATMENT	WHEN DID YOU LAST TREAT PATIENT?
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LIST OF MEDICATIONS TAKEN FOR DISABLING CONDITION

Submit clinical summary and/or current supporting documentation of disabling condition. For mental conditions, include current IQ test results if available.

**EXTENT OF DISABILITY**

IS PATIENT NOW INCAPABLE OF SELF-SUPPORT BECAUSE OF A DISABILITY?    YES    NO  
INDICATE CURRENT FUNCTIONAL CAPABILITIES AND LIMITATIONS

HAS SUCH DISABILITY EXISTED CONTINUOUSLY SINCE BEFORE THE PATIENT ATTAINED AGE 19?  
 YES    NO

DO YOU THINK PATIENT WILL BE ABLE TO RETURN TO GAINFUL EMPLOYMENT?  
 YES, INDICATE APPROXIMATE DATE:    INDEFINITE    NEVER

PHYSICIAN NAME	PHYSICIAN PHONE		
PHYSICIAN ADDRESS	CITY	STATE	ZIP

**For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

INTERNAL OFFICE USE ONLY



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**TO BE COMPLETED BY COVERED EMPLOYEE**

EMPLOYEE'S NAME		SOCIAL SECURITY NUMBER		DATE OF BIRTH	
HOME ADDRESS		CITY		STATE	ZIP
GROUP NAME				TELEPHONE NUMBER	
EMPLOYER				DATE OF HIRE	

**INFORMATION ABOUT INCAPACITATED CHILD**

CHILD'S NAME			RELATIONSHIP TO EMPLOYEE		
DATE OF BIRTH		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		CHILD'S AGE WHEN DISABILITY OCCURRED	
DESCRIBE DISABILITY					

IS CHILD DEPENDENT ON YOU FOR SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE INDICATE PERCENTAGE SUPPORT:
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IS CHILD LISTED AS A DEPENDENT ON YOUR LAST FEDERAL INCOME TAX RETURN? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF NO, PLEASE INDICATE WHY NOT:

IS CHILD PERMANENTLY RESIDING IN YOUR HOUSEHOLD? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF NO, PLEASE INDICATE WHY NOT:

IS THIS DEPENDENT CURRENTLY A FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
NAME OF SCHOOL	HOURS ATTENDED DAILY

IS CHILD RECEIVING SOCIAL SECURITY DISABILITY INCOME? <input type="checkbox"/> YES <input type="checkbox"/> NO
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IS CHILD COVERED UNDER ANY OTHER HOSPITAL OR MEDICAL COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, PLEASE GIVE NAMES OF INSURANCE COMPANIES AND POLICY NUMBERS

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Signature of Employee _____	Date _____
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