LifeMap | P.O. Box 1271, M/S E8L
Portland, OR 97207

LifeMap Assurance Company®

Life and Disability Claims Department
Toll-free 1 (800) 286-1129
Fax (855) 733-4615
claims@lifemapco.com

LifeMapCo.com

Affidavit of Qualified Disabled Dependent

Disabled Dependent Application Instructions

This Affidavit of Qualified Disabled Dependent includes the forms required to apply for continued benefits for your Disabled Dependent.

If a form is received incomplete, unsigned or undated, it will be returned to you for completion.

You must…

1. complete in full, sign and date the Insured's Statement.

2. have the physician treating your dependent complete, sign and date the Attending Physician's Statement, and have it returned to you.

3. You are responsible for ensuring all forms are completed and returned to our office within 31 days of the later of; the child's 26th birthday or your Effective Date if you become eligible to enroll for coverage after your child's 26th birthday.

4. Forms can be sent to LifeMap via:

   Email: **claims@lifemapco.com**

   Fax: **1 (855) 733-4615**

   Regular Mail: **LifeMap Assurance Company**
   Attn: Life and Disability Claims Department
   PO Box 1271, M/S E8L
   Portland, OR 97207-1271

If you have any questions, please call the LifeMap Claims Department at 1 (800) 268-1129.

You must notify LifeMap promptly if:

- Your disabled child's medical condition improves so that he/she will be able to work, even though they have not yet returned to work.
- He/she goes to work in any capacity for any employer, or as a self-employed person

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A dependent child who is age 26 or over may continue to be covered under your plan if they are incapable of self-support because of total disability that began before their 26th birthday. Please complete and return this form to apply for ongoing coverage for you or your Spouse's dependent child.
IMPORTANT NOTE: This form must be completed and submitted to LifeMap office within 31 days of the later of; the child's 26th birthday or your Effective Date if you become eligible to enroll for coverage after your child's 26th birthday.

Insured's Statement

Information about Employee

Employer/Policyholder Name		**Group Policy #**	
Employee (Last Name, First Name Middle Initial)		**Social Security Number/Member ID**	
Employee's Address	**City**	**State**	**Zip Code**

Information about Dependent

Dependent (Last Name, First Name Middle Initial)			
Dependent's Relationship to Employee		**Dependent's Birthdate**	
Dependent's Address (if not residing with Employee)	**City**	**State**	**Zip Code**
Please explain (if applicable) why dependent does not live with Employee			
Does dependent have other health insurance coverage? ☐ Yes ☐ No If Yes, please provide the name of the carrier, Employee name, policy number and carrier's phone number:			

I certify _____ , meets the following criteria:
name of the incapacitated dependent (please print)

1. Is incapable of engaging in substantial gainful activity due to total disability related to physical and/or mental disability and is determined to be totally disabled prior to turning age 26; and
2. Is primarily dependent upon Employee (and/or Employee's spouse) for support; and

I certify the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge I have read the fraud notice attached to this form.

_____ _____
Employee Signature **Date**

Please have your dependent's provider complete and sign the Attending Physician's Statement

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Insurance Fraud Notice

Unless specific state language is provided below, the following fraud notice applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Arizona Residents: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Alabama, Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas and West Virginia Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Ohio Residents: 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.

Maine, Tennessee, Virginia and Washington Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Alaska and Oregon Residents: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

Delaware, Idaho, Indiana and Oklahoma Residents: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

LifeMap FN V8/14

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Attending Physician's Statement

Information about Patient

Patient's Name	Patient's Birthdate

Date patient was last examined by Provider:	Nature of condition causing incapacity:
	☐ Developmental Disability ☐ Medical Disability ☐ Mental Disorder ☐ Other (please explain) _____
Incapacitation is: ☐ Complete ☐ Partial _____ % incapacitated	**Incapacitation is:** ☐ Temporary (estimated duration is) _____ ☐ Permanent At what age did patient become incapacitated? _____

Diagnosis of Condition Causing Incapacity Give as much detail as possible. Please give dates of surgery, forward laboratory data and results of special tests, such as x-rays, EKG's EEG's, etc. If intellectual disability is present, please note severity of disability and IQ test score. Attach additional pages as necessary.

Diagnosis: _____

_____

_____

Comments to Support Incapacity: _____

_____

_____

_____

_____

Is patient now or will patient be capable of self-support? ☐ Yes ☐ No

If Yes, when? _____

Is patient able to perform full or part-time work of any kind? ☐ Yes ☐ No

Does the patient have a job? ☐ Yes ☐ No ☐ Unknown

If yes, do you know what duties the patient's job requires? ☐ Yes ☐ No

Please explain: _____

Provider's Name		Specialty		Telephone Number
Provider's Address	**City**	**State**	**Zip Code**	**Fax Number**

I certify the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge I have read the fraud notice attached to this form.

_____ _____

Signature of Attending Physician **Date**

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New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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LifeMap FN V8/14