Mail: P. O. Box 4100 · Concord, CA 94524-4100
Telephone: (800) 552-2400 · Facsimile: (925) 746-7549
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APPLICATION FOR EXTENDED MEDICAL BENEFITS

(PPO Plan Members Only)

(Extension of Medical Benefits for a Specific Disability— this application form must be returned within 60 days from the date you received your COBRA Application or within 60 days of the time *Earned Coverage terminates)

If you or your Dependent is Totally Disabled at the time *Earned Coverage terminates, you may apply to have the disabled person's medical benefits extended for treatment of the disabling illness or injury **only**, provided the disabled person is not covered by another medical plan, and provided you timely apply for such extended medical coverage. Prescription charges are also covered if they are directly related to the disabling condition and are paid under the Medical plan benefit (i.e. subject to Deductible and Coinsurance). Please note that if you elect an Extension of Medical Benefits, this benefit is in lieu of COBRA coverage. This means that if an Extension of Medical Benefits is elected, the disabled person is forfeiting their right to COBRA coverage, if COBRA is not elected prior to expiration of the COBRA election period. However, any COBRA coverage elected after the commencement of an Extension of Medical Benefits shall be prospective only and shall not extend the COBRA coverage period. Please refer to the COBRA notice for further information.,

If granted, an Extension of Medical Benefits will end at the earliest of the following:

- The date you or your Dependent is no longer Totally Disabled;
- 12 months from termination of Earned Coverage;
- Voluntary termination of coverage; or
- The date the disabled person becomes covered under another plan that provides similar benefits for the disabling illness

*Earned Coverage means only coverage as a result of Employer contributions to the Fund (hours worked or compensated). FMLA leave, disability extensions, COBRA and Self-Pay are not Earned Coverage, and will run concurrently with this extension of medical benefits.

MEMBER SECTION (TO BE FILLED OUT BY MEMBER ONLY)

1. MEMBER

Member Name PLEASE PRINT:

Last Name: _____ First Name:_____ Middle Initial:_____

Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ or Member ID # _____

2. PATIENT

Name of Patient PLEASE PRINT:

Last Name: _____ First Name:_____ Middle Initial:_____

Date of Birth: _____/_____/_____
MM DD YYYY

3. Do you have any other medical benefits (Group Health Plan or Government Agency): ☐ Yes ☐ No

4. Is this injury related to work or subrogation: ☐ Yes ☐ No

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I hereby authorize any physician, any hospital or insurance company to furnish and disclose all known facts concerning this disability. A copy or photocopy of this authorization shall be as valid as the original.

MEMBER SIGNATURE: _____ Date: _____

PHYSICIAN SECTION (TO BE FILLED OUT BY ATTENDING PHYSICIAN ONLY)

1. DIAGNOSIS

Disability that prevents the above patient from working or attending school: _____

Most applicable diagnosis code(s): _____

2. EXTENDED DISABILITY

	For Attending Work/School	For Any other Occupation
(a) Is patient now totally disabled?	Yes No	Yes No
(b) Patient has become continually disabled?	_____/_____/_____ (MM DD YYYY)	_____/_____/_____ (MM DD YYYY)
(c) If "Yes", when will patient be able to resume *any* work/school?	_____/_____/_____ (MM DD YYYY)	_____/_____/_____ (MM DD YYYY)
(d) (d) If "No", when was patient last able to go to work/school?	_____/_____/_____ (MM DD YYYY)	_____/_____/_____ (MM DD YYYY)

REMARKS: (PLEASE PRINT)

Attending Physician's SIGNATURE: _____ Date: _____

Federal Tax ID#: _____ Telephone #: _____

Attending Physician's name PLEASE PRINT: _____ Degree:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____