



Request For Coverage For a Physically or Mentally Disabled Dependent Child

Section I — To be Completed by Subscriber

RMHMO or RMHCO will not request or require medical information from more than 5 years before the date of application.

Name of Subscriber: _____ Address: _____

Name of Dependent: _____

Social Security # of Dependent: _____ Dependent's Date of Birth: _____ / _____ / _____
Month Day Year

Dependent's Marital Status: Single Married Divorced Widowed

Date of Disability: _____ / _____ / _____
Month Day Year

Is your Dependent eligible for care under federal, state or local law? Yes No

If yes, give details: _____

I hereby certify that I am the dependent's parent and that the dependent named above is dependent upon me. Yes No

If yes, give details: _____

Subscriber's Signature

Date

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.

Section II — Must Be Completed by Physician

I hereby certify that I am familiar with the dependent named above, and that the dependent is medically disabled.

Yes No

If yes, please give details of disability below:

Physical Disability _____ (circle one) Permanent /Temporary

Mental Disability _____ (circle one) Permanent /Temporary

Diagnosis of condition causing disability status: _____

Physician's Signature

Date