



Dear MESSA member,

Dependent adult children age 25 and older with a severe physical or intellectual impairment are eligible for continued MESSA coverage beyond the end of the calendar year in which they turn 25, and continuously thereafter under certain circumstances.

Coverage may be approved for a single year or longer, as determined by MESSA's medical director.

MESSA requires two forms and pertinent medical records; one form must be completed by your child's treating physician.

In addition to the forms, you must submit:

- A current (within the last 12 months) physical exam detailing impairment, including information that shows dependent is incapable of self-sustaining employment by reason of the impairment.
- A list of medications and treatment plan.
- If applicable, intelligence test results.

You will receive written notification if continuing coverage is approved.

If you have any questions, please contact MESSA's Member Service Center at 800.336.0013.



Return this completed form, the completed physician form and all supporting documentation to MESSA Group Services at the address at the bottom of this page or by fax at 517.203.2914.

Application for continued dependent adult child coverage for an individual who is incapable of self-sustaining employment due to a severe physical or intellectual impairment.

Dependent adult children age 25 and older with a severe physical or intellectual impairment are eligible for continued coverage beyond the end of the calendar year in which they turn 25 and continuously thereafter, provided they are unmarried, dependent on the member for support and maintenance and incapable of self-sustaining employment by reason of the impairment.

The eligibility criteria are strict. MESSA requires detailed documentation from the treating physician that includes the diagnoses contributing to the severe physical or intellectual impairment, a physical exam, and a statement why the dependent adult child is incapable of self-sustaining employment by reason of the impairment. MESSA is unable to approve coverage for a dependent adult over age 25 unless all of the required documentation from the treating physician is submitted with this application.

MESSA member name: _____

Member ID or SSN: _____

Street address, city, state and ZIP Code: _____

Phone number: _____

School district: _____

Dependent full name: _____

Dependent date of birth: _____

	<i>Circle one</i>	
1. Is this dependent married?	Yes	No
2. Do you provide support and maintenance for this dependent?	Yes	No
3. Is dependent currently or have they ever been employed? Attach complete employment history.	Yes	No
4. Is dependent receiving Social Security income or Social Security disability benefits? Answering "yes" does not automatically qualify child for coverage.	Yes	No
5. Is dependent receiving Medicare? Please include copy of Medicare card.	Yes	No

Treating physician (*Treating physician must complete physician statement form and provide required documentation*)

Other treating physicians' names and addresses (*Attach additional sheets if necessary*)

I have attached the physician's statement form completed by the treating physician and supporting medical records. I consent to the release to and by MESSA of medical, hospital and other information necessary to determine eligibility of my dependent for continued coverage. I have truthfully answered the questions above. I understand that if my application is not complete or does not include the required documentation, it may result in my dependent's coverage being cancelled.

MESSA member signature	Date
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Treating physician statement

Application for continued dependent adult child coverage for an individual who is incapable of self-sustaining employment due to a severe physical or intellectual impairment.

Patient is responsible for fee charged by physician for completion of this form.

Criteria for this coverage are strict. Please attach all pertinent medical records documenting the medical diagnosis and prognosis, including:

- A current (within the previous 12 months) physical exam detailing impairment, including information that shows dependent is incapable of self-sustaining employment by reason of the impairment.
- A list of medications and treatment plan.
- If applicable, include intelligence test results.

MESSA member name: _____

Member ID or SSN: _____

Street address, city, state and ZIP code: _____

Phone number: _____

School district: _____

Dependent full name: _____

Dependent date of birth: _____

Medical diagnosis and prognosis *(Attach additional sheets if necessary)*

Does dependent have (check one):	<input type="checkbox"/>	Temporary disability	<input type="checkbox"/>	Permanent disability
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Detail medical reasons dependent is incapable of self-sustaining employment by reason of the impairment. Include prognosis. *(Attach additional sheets if necessary.)*

Physician name	Specialty
Address	Phone
Physician signature	Date

Return to: MESSA Group Services • PO Box 2560 • 1475 Kendale Blvd • East Lansing, MI 48826-2560