DISTRICT NO. 9, I. A. OF M. & A. W. WELFARE TRUST
12365 St. Charles Rock Road ■ Bridgeton, MO 63044
(314) 739-6442 ■ (888) 739-6442 ■ fax (314) 739-2374 ■ www.d9trusts.org

INCAPACITATED CHILD FORM

Member Information

Last Name:	First:	Middle Initial:	Member ID #:	
Home Address:	City:	State:	Zip:	Employment Date:

Child Information

Last Name:	First:	Middle Initial:	Gender: Male Female	Social Security #:
Child Address:	City:	State:	Zip:	Date of Birth:

- If dependent turned 26 before coverage under District #9 Welfare Trust, was the dependent extended coverage by the prior carrier? Yes No Not Applicable

  If yes, send verification of the prior carrier extended coverage. This may be copies of claims paid after the dependent attained the maximum age, or a copy of the letter from the prior stating they extended coverage.

- Has dependent ever been employed? Yes No

  If yes, give most recent date of employment and type of employment:____

  ____

- Are you the sole means of the dependent's support? Yes No

  If no, explain: ____

- Give most recent date dependent consulted or was treated by a physician: ____________________________________

  ____

Must Include:	1. A report or letter from the dependent's personal physician giving the physician's opinion of the dependent's present health status and the prognosis, including in the statement the doctor's opinion as to whether or not the dependent is or will be capable of earning his or her own living. 2. A copy of the dependent's social security entitlement and/or disability letter.

I certify that the above information is true and correct and that any incorrect or inaccurate information can result in a loss of benefits. I understand that misrepresentation in answering the questions on this form may constitute fraud under applicable state and federal statutes.

Signature of Member: ____ Date: _________________