BorgWarner

Medical Coverage Extension Request
For Handicapped Adult Dependent Child

Employee Statement: (Submit the completed Employee Statement and Physician Statement to your local HR Representative within 31 days of change in dependent eligibility. If forms are not returned in a timely manner, your dependent's medical coverage may terminate.)

Date:	Employee Name:		Employee SSN:
Street Address:	City:	State:	Zip Code:
Dependent Name:	Dependent Relationship:	Dependent Birth Date:	Dependent SSN:

Does the dependent have other medical coverage, or eligible for other coverage? Yes ☐ No ☐	If yes, date plan started (mm/dd/yy): Name and telephone number of other medical carrier: List other coverage available:	
When did the incapacity start (mm/dd/yy)?	Did incapacity occur while the dependent was covered under age 19, and on a BorgWarner Inc. medical plan? Yes ☐ No ☐	Has the dependent attended school since reaching age 19? Yes ☐ No ☐

Do you provide more than 50% financial support for this dependent? Yes ☐ No ☐	If no, please explain:
Do you claim the dependent on your Federal Income Tax return? Yes ☐ No ☐	If no, please explain:

Employee Authorization and Release:	I authorize my health carrier, any independent claim administrator and consulting health professionals and utilization review organizations with whom my health carrier has contracted with, information concerning health care advice, or treatment and supplies provided for my incapacitated dependent. This authorization expires three years after the begin date of the coverage extension of this request. This authorization is invalid if coverage extension is not approved. I have the right to receive a copy of this authorization upon request and agree that a photocopy is as valid as the original. Employee's Signature ____________ Date ____________
Employee Acknowledgement:	It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. The information provided above is true and complete to the best of my knowledge. I understand that if I have provided any false, misleading or omitted information, I may be subject to disciplinary action up to, and including termination. I also understand that the Company may seek reimbursement from me on any and all claim amounts paid on behalf of my ineligible dependent. Employee's Signature ____________ Date ____________

For HR Use Only: ***Approved*** ☐ ***Denied*** ☐ ***Reason for denial:*** ____________

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HR Representative Signature & Title ____________ Date ____________ Extension Begins ____________ Extension Ends ____________

03/28/2007

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Attending Physician Statement: (The employee completes the shaded area only. The dependent's attending physician must complete the remainder of the form - please complete within 10 days and return to the employee.)

Employee- Complete the Shaded Area Only	Employee Requesting Coverage Extension:
	Dependent Name:
	Dependent Birth Date (mm/dd/yy):

Attending Physician Name:

Street Address: City: State: Zip Code:

Diagnosis: *(Attach additional pages if necessary)* ☐ Mental Incapacity ☐ Physical Incapacity

Date you first attended dependent (mm/ddy/yy):	Date you last seen the dependent (mm/dd/yy):
When was the dependent incapacitated (mm/dd/yy)?	How long is the incapacity expected to continue?

List treatment(s) given to the dependent, and expected to receive:

Current state & prognosis:

In your opinion, is the dependent capable of self-support? Yes ☐ No ☐ If no, explain:

Can this dependent perform any type of work? Yes ☐ No ☐ If yes, explain:

List other treating physician names, addresses, and telephone numbers you are aware of that treat the dependent for his/her incapacity. *(Attach additional pages if necessary)*

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______________________________________ ______________

Attending Physician's Signature Date

Misrepresentation Statement:
Any person who knowingly and with intent to defraud any insurance company or other person files a 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.