

## **Notice of Personal Information**

**The following notice is provided in accordance with Section 559.003(a) of the Texas Government Code:**

- 1. With few exceptions, you are entitled on your request to be informed about the information The University of Texas System Administration collects about you;**
- 2. Under Sections 552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review the information; and**
- 3. Under Section 559.004 of the Texas Government Code, you are entitled to have The University of Texas System Administration correct information about you that is held by The University of Texas System Administration and that is incorrect, in accordance with the procedures set forth in The University of Texas System Business Procedures Memorandum 32, *Texas Public Information Act*.**

**The information that The University of Texas System Administration collects will be retained and maintained as required by Texas records retention laws (Section 441.180 et seq. of the Texas Government Code) and rules. Different types of information are kept for different periods of time.**

**The University of Texas System Employee Group Insurance  
Coverage For Incapacitated Child Form**

Employee's Name		Social Security Number	
Component Name	Component Contact	Component Phone Number	Component Fax Number
Please Indicate Plan		Group Number	

**PART ONE - EMPLOYEE'S CERTIFICATION**

This is to certify that \_\_\_\_\_ (Name of Dependent) \_\_\_\_\_ (Date of Birth)

- (1) is unmarried and,
- (2) is mentally or physically incapable of earning his/her own living, and
- (3) became so incapable prior to the attainment of age 25, and
- (4) is chiefly dependent upon me for support and maintenance.

I request continuance of insurance which would otherwise terminate on attainment of age 25 and/or coverage for my incapacitated child who is not currently covered on a UT medical plan.

I understand that no liability for claim on part of the Insurance Company exists with respect to any period of time prior to the receipt of this form by the Insurance Company at its home office.

(5) Date \_\_\_\_\_ X \_\_\_\_\_ (Employee's Signature)

<p><b>I authorize</b> any physician, medical practitioner, hospital, clinic or other medical facility, insurance or reinsurance company, Medical Information Bureau, Inc. to give the Plan or its legal representative all medical and other personal information it holds which is needed to determine eligibility for this insurance. The Plan may disclose this data to its reinsures, Medical Information Bureau, or other insurance companies. I, as well as anyone authorized to act on my behalf, have the right to receive a true copy of this authorization. I agree that any true copy will be as valid as the original. This authorization will be valid for two and on-half years from the date signed.</p> <p>(6) Date _____ Patient's or Authorized Person's Signature _____</p>
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**PART TWO - ATTENDING PHYSICIAN'S STATEMENT**

- (1) Describe the dependent's physical or mental handicap:
- (2) Date of Onset: \_\_\_\_\_
- (3) Cause(s) if known: \_\_\_\_\_
- (4) Is named dependent-because of said handicap-incapable of self-support and employment?  
 Yes       No

**Please attach additional medical information to support the condition described in number (1) above.**

Date \_\_\_\_\_ By \_\_\_\_\_ M.D.  
(Physician's Signature)