# Continuation of Benefit Coverage for Incapacitated Dependent Child

**Chevron currently allows an eligible dependent child to continue certain benefit coverage* beyond the maximum allowed age if the eligible dependent child meets the applicable benefit plan's definition of an incapacitated (or disabled) child.** Your eligible dependent child must generally meet *all* the following requirements:

- Be incapable of self-sustaining employment because of a mental or physical disability, proof of which must be medically certified by a physician.
- Be dependent on you, you and your spouse/domestic partner, or your surviving spouse/domestic partner, who is covered under the Omnibus Health Care Plan of Chevron Corporation and other applicable benefit plan(s), for more than one-half of his or her financial support.
- Is your or your and your spouse/domestic partner's qualifying child under section 152 of the Internal Revenue Code. This means that during the calendar year the individual; 1) is your child, brother, sister, stepbrother, stepsister or a descendent of such person 2) lives with you for more than one-half the year and 3) does not provide over one-half of his or her own support.

Enclosed is the **Request for Continuation of Coverage for Incapacitated Dependent Child** form. You are receiving this form because you have an eligible dependent child who will soon reach the maximum allowed age but that you believe is eligible to continue benefit coverage due to meeting the definition of an incapacitated (or disabled) child. You must return the completed form and any required documentation to the Chevron Human Resources Service Center prior to **00/00/0000** to avoid cancellation of coverage. Once cancelled, coverage cannot be reinstated.

**Part 2 of this form requires completion by an attending physician; plan accordingly to ensure your physician's statement is obtained prior to your stated deadline.** Please reference the enclosed form for further instructions regarding required proof documentation and how to return all materials prior to the stated deadline. If you have questions, call the HR Service Center at 1-888-825-5247.

If you commit fraud or make an intentional misrepresentation of a material fact about your participation in Chevron's benefit, the plan has the right to terminate coverage permanently for you and all of your eligible dependents. Also, the plan may seek financial damages caused by the misrepresentations and may pursue legal action against you. Material misrepresentation includes, but is not limited to, adding a dependent who is ineligible (for instance, adding a spouse when you aren't married or adding a child who doesn't meet the plan qualifications of an eligible dependent).

** Under current provisions, coverage may be continued under Chevron medical plans, dental plans, Vision Plus Program, Mental Health and Substance Abuse Plan, Group Critical Illness Insurance, Group Hospital Indemnity Insurance, Dependent Life Insurance Plan, Voluntary Group Accident Insurance Plan, and the Retiree HRA Plan.*

# Request for Continuation of Coverage for Incapacitated Dependent Child

Under current Chevron benefit plan provisions regarding an incapacitated (or disabled) child, you are required to provide documentation to substantiate a request for continuation of coverage after the applicable plans' usual age limit for eligible dependent children. You must return the following to the Chevron HR Service Center *prior to* your stated deadline:

- This *completed* form, **Request for Continuation of Coverage for Incapacitated Dependent Child**.
- Proof of your child's financial dependency in the form of the **first two pages of federal tax returns for the prior three years** for you, you and your spouse/domestic partner, or the surviving spouse/domestic partner.
- Please be aware that **Part 2** of this form requires completion by an attending physician. Be sure to plan accordingly to ensure your physician's statement is obtained prior to your stated deadline. Part 2 must be fully completed for this form to be considered valid.

Choose any *one* of the following options to return the completed form and supporting documentation:

- **Mail** the documents to the Chevron HR Service Center at DEPT: CVXH PO BOX 981901 EL PASO TX 79998.
- Use the **Message Center** on the BenefitConnect website to upload your documents. Go to **hr2.chevron.com** and click **BenefitConnect** to get started.
- **Fax** your documentation to 1-844-301-6998.
- Keep a copy for your files.

**Part 1 – Employee's, Retiree's or Survivor's Statement** (Print in ink.)

Address _____
No. & Street City State ZIP code

Name of Dependent Child _____ Child's Birth Date _____
First Middle Initial Last

Child's Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Is child dependent upon you for more than half of his or her support? ☐ Yes ☐ No Attach proof of financial dependency.

Does the child reside with you? ☐ Yes ☐ No

**Part 1 – *Continued***

If child is not living with you, state where child is living and who is paying his or her expenses:

Is the child covered by federal Medicare? ☐ Yes ☐ No

Is the child employed now? ☐ Yes ☐ No

Was child ever employed? ☐ Yes ☐ No

If answer to either question on child's employment is "Yes," give name(s) and address(es) of employer(s) and dates of employment:

## Part 1 – *Continued*

**Summary of any institutional care**

| Names of Institutions | Dates | Nature of Care |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Signature of Employee, Retiree or Survivor _____ Date _____

Social Security Number (REQUIRED)
of Employee, Retiree or Survivor _____

## Part 2 – Attending Physician's Statement

You are responsible for obtaining physician's statement at your own expense. (Print in ink.)

Is child now incapable of sustaining employment or self-support because of this mental or physical disability? ☐ Yes ☐ No

Did such incapacity exist prior to child's attainment of age 26? ☐ Yes ☐ No

May child be employed in the future? ☐ Yes ☐ No ☐ Questionable

What is the child's IQ? _____

**Describe nature of disability**
Please give as many details as practicable, including all applicable diagnosis codes.
Use other side of sheet, if necessary.

_____

_____

_____

_____

Date of Onset (when the child's disability occurred) _____

Prognosis (estimate months or years) _____

Name of Physician _____ Degree _____

Physician's Signature _____ Date _____

Address _____

No. & Street City State ZIP code