·APTIV·

Certification of Child's Eligibility for Health Care Continuation Due to Total and Permanent Disability

Please complete and return this form to the Fidelity Benefits Center. **You must sign and date this form and you must have your child's physician complete and sign the attached physician certification form.** After both forms are completed, please contact Fidelity Benefits Center at 1-877-389-2374, Monday through Friday 8:30 a.m. - 8:30 p.m. ET., for further instructions on how to submit this form.

TO BE COMPLETED BY THE EMPLOYEE:

I hereby certify that my child is "totally and permanently disabled" under applicable provisions of the Aptiv Health Care program. I understand that for this purpose, totally and permanently disabled means "having any medically determinable physical or mental condition which prevents the child from engaging in substantial gainful activity and which can be expected to result in death or be of long-continued or indefinite duration."

1. State cause of your child's disability _____

2. On what date did your child's disability commence? _____

3. On what date did treatment by a physician for this disability commence? _____

4. Identify all physicians who have treated your child since the beginning of this disability. *(attach another sheet if necessary)*

Name	**Address** (Street City, State, Zip)	**From** (Date)	**To** (Date)

5. If your child has been or is now hospitalized in connection with this disability, note the location and dates of hospitalization:

Name of Hospital	**From** (Date)	**To** (Date)

6. Is your child married?
   ☐ YES ☐ NO

7. Does your child live with you, or are you legally responsible to provide health care for your child due to a court order?
   ☐ YES ☐ NO

I represent that I have made and read the answers to the foregoing questions and that said answers are true and correct to the best of my knowledge. I herewith authorize any physician or surgeon who has treated or examined my dependent or whom I have consulted on behalf of my dependent for any purpose, and any insurance company or organization to which I have applied for insurance for my dependent, to divulge and make available to Aptiv Corporation, or its designated representatives, any and all information and data or whatsoever kind or character, which they, or any one of them, may have concerning my dependent.

Employee Name *(please print)* **Telephone Number** **Employee ID**

Child's Name *(please print)* **Child's Social Security Number** ___ – ___ – ____

Employee Signature **Date**

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Certification of Child's Physician

TO BE COMPLETED, SIGNED, AND DATED BY THE PHYSICIAN (M.D. or D.O.) of EMPLOYEE'S DEPENDENT:

1. Patient's full name _____ Date of Birth _____ SSN _____
2. Date that you were first consulted on account of the present sickness or injury: _____
3. (A). What is the diagnosis? _____

   (B). What is the prognosis? _____
4. (A). What treatment(s) have been given? _____

   _____

   (B). Are you the present attending physician? ☐ YES ☐ NO Date of last examination: _____
5. (A). State the causes of this disability: _____

   _____

   (B). Were diagnostic studies/tests employed in making diagnostics? ☐ YES ☐ NO *If yes, please attach pertinent findings/reports*
6. (A). How has the patient reacted to treatment(s)? _____

   _____

   (B). Is the patient confined to bed, at home or hospitalized? _____ If so, how long is such confinement expected to be necessary? _____
7. (A). Will the condition prevent the child from engaging in substantial gainful activity and will it be expected to result in death or be of long-continued or indefinite duration? ☐ YES ☐ NO

   (B). If "YES," or answer is qualified, describe any work limitations: _____
8. (A). Are you currently providing the patient any medical treatment? ☐ YES ☐ NO

   (B). If "YES," what type of treatment? _____

   (C). If "YES," how long have you been treating this patient for this condition? _____

   (D). Are you the patient's regular family physician? ☐ YES ☐ NO

Physician Name *(Please Print)*: _____ ☐ M.D. ☐ D.O

Office Address *(Number and Street)*: _____

City: _____ State: _____ Zip Code: _____

Office Phone: (_____) _____ - _____

Specialty: _____ Board Certified: ☐ YES ☐ NO

State License: ☐ YES ☐ NO License Number: _____ Date Certified: _____

Physician Signature **Date**

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Response to request for Health Care Continuation Due to Child's Total and Permanent Disability

TO BE COMPLETED BY APTIV EMPLOYEE BENEFITS

A totally and permanently disabled (T&PD) child may have coverage continued if they continuously meet the Aptiv Health Care Program's definition of T&PD status (i.e., having any medically determinable physical or mental condition that prevents a child from engaging in substantial gainful activity and that can be expected to result in death or be of long-continued or indefinite duration), and continue to meet all other applicable health care eligibility requirements.

Your request for a Total and Permanent Disability designation for your child under the Aptiv Health Care Program has been:

☐ **Approved.**
Based on the information presented, it has been determined that this child meets the definition of "totally and permanently disabled". This decision may be reviewed in the future, at its discretion, Aptiv may require this form to be completed with updated information.

☐ **Denied.**
Based on the information presented, it has been determined that this child does not meet the definition of "totally and permanently disabled".

_____ _____
Aptiv Employee Benefits Signature **Date**