som\_currentexporteddate

Firstname and lastname

address1\_line1 address1\_line2

address1\_city address1\_stateorprovince address1\_postalcode

Dear salutation lastname

This letter is in response to your inquiry to have your som\_dependent birthdate Deemed as an incapacitated dependent on your state – sponsored insurance benefits.

Based on the Information that was submitted to som\_carrier som\_dependent doesn’t not meet the criteria for the continued coverage as an incapacitated dependent, therefore your request has been denied

som\_carrier has indicated that your physician stated som\_dependent was diagnosed with som\_diagnosis. Add information regarding why this is not sufficient, the application cannot be approved at this time. However, if the prognosis changes, please have the physician resubmit the application for the review At that time. You have 31 days form the termination of benefits to submit documentary verifying your child’s incapacitated state.

If you have any question, please contact the Employee benefits Division at 800-505-5011

Sincerely,

Keri Rust

Benefits Administrator

Employee Benefits Division