



## DEPENDENT STUDENT MEDICAL LEAVE OF ABSENCE FORM

Public law 110-381, also known as “Michelle’s Law” may provide continued coverage for your dependent student. If your dependent child is on a medically necessary leave of absence from school, or has had a change in enrollment, then he or she may be eligible to continue coverage under the plan in accordance with Michelle’s Law. In order to qualify for this continued coverage, the dependent must be suffering from a serious illness or injury and the leave of absence or other enrollment changes must be medically necessary, as determined by the treating physician. Such dependents may remain covered up to the earlier of: one year after the first day of the medically necessary leave of absence; **or** the date on which such coverage would otherwise terminate under the terms of the plan. **If your child will continue coverage under Michelle’s Law, you must fill out this form in its entirety and fax it to: 985 871 1855; or return it by mail to: Gilsbar, Inc., Attn: Administration Dept., P.O. Box 998, Covington, LA 70434; or by emailing it to: [AdminServices@gilsbar.com](mailto:AdminServices@gilsbar.com)**

Group Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Dependent Name: \_\_\_\_\_

Member ID (as shown on your ID card) #: \_\_\_\_\_

I hereby certify that the above information is true and complete.

\_\_\_\_\_  
Signature of Covered Employee

\_\_\_\_\_  
Date

### Certification of Student Medical Leave:

If the dependent is seeking a medically necessary leave of absence from school, in addition to the information provided above, the dependent’s physician must complete the following and sign below:

The undersigned physician hereby certifies that the above-named dependent student is suffering from a serious illness or injury and that the dependent’s leave of absence (or other change in enrollment of the dependent at the school) is medically necessary.

Describe dependent’s medical condition (attach additional information if necessary):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the leave of absence or other student enrollment change medically necessary?  Yes  No

Date of dependent’s medical leave: Beginning Date: \_\_\_\_\_ End Date: \_\_\_\_\_

I hereby certify that the above information is true and complete.

\_\_\_\_\_  
Printed Name of Attending Physician

\_\_\_\_\_  
Signature of Attending Physician

\_\_\_\_\_  
Date