

## Disabled Dependent Certification

After completing Section A, please forward this form to your physician for his or her completion

### Section A—Employee Information

Employee Last Name										Group #						
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>										<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>						
Employee First Name										Middle Initial						
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Employee Social Security Number																
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Group Name																
Employee Address										City			State		Zip	
Date Disabling Condition Occurred					Dependent Name					Dependent Birth Date			Dependent Marital Status			
Does the dependent reside in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No					Is he or she more than 50% dependent upon you for support? <input type="checkbox"/> Yes <input type="checkbox"/> No					Is he or she listed as dependent on your last income tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Is dependent employed? <input type="checkbox"/> Yes <input type="checkbox"/> No					If yes, date of hire					Number of hours employed per week						
Describe nature of duties																
I certify that the above information is correct and authorize the release of medical information requested with respect to this certification																
<b>X</b> _____										_____						
SIGNATURE OF SUBSCRIBER										DATE						

### Section B—To be completed by attending physician

*A dependent child who is incapable of self-support due to a continuously disabling illness or injury may be continued as a family member on the parent's health coverage. Your medical statement will help us determine the eligibility of this dependent.*

Please give us the specifics as to the nature of the disability (attach supporting documentation)

\_\_\_\_\_

\_\_\_\_\_

To what extent does the disability limit normal activity? (attach supporting documentation)

\_\_\_\_\_

\_\_\_\_\_

What is your prognosis, including your estimates of length of time this disability may be expected to continue? (attach supporting documentation)

\_\_\_\_\_

\_\_\_\_\_

Physician signature			Name of physician			Date signed		
Address			City			State		Zip