



Disabled Dependent Certification

TO BE COMPLETED BY EMPLOYEE

1. Employee Name	Last	First	MI
2. Employee Address	Number & Street	City	State/Zip Code
3. Name of Dependent Child	Child's Birth Date		Child's Marital Status
Child's Relationship to Employee	Child's Gender		Child's Age When Disability Occurred

4. Is child permanently residing in your household? Yes No
5. Is child dependent upon you for support? Yes No
- a. If "Yes", what part of support do you contribute? _____
- b. Is child listed as a dependent in your last Federal Income Tax Return? Yes No
6. Was child ever employed? Yes No
- a. Is child employed now? Yes No
- b. If answer to question 6 or 6a is "Yes", give name(s) and address(es) and date(s) employed on reverse side of this form.
7. Was child covered under your present employer's insurance program immediately prior to attainment of age 19? Yes No
8. Is child now covered under any other hospital-medical coverage? Yes No
- a. If answer is "Yes", furnish insurance company name, group, certificate or agreement number on reverse side of form.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.

Signature of Employee: _____ Date: _____

TO BE COMPLETED BY PHYSICIAN

1. Is the child now incapable of self-support because of a disability? Yes No
2. Has such disability existed continuously since before child attained age 19? Yes No
3. Diagnoses and extent of disability (*please give as much detail as possible – use reverse side if necessary*).

4. Prognosis (*estimated months or years*).

Name of physician (print or type) _____ Degree _____

Physician Signature _____ Date _____

Address of physician (print or type) _____

TO BE COMPLETED BY EMPLOYER

1. Was the employee enrolled for dependent coverage immediately prior to the date the above named child attained age 19? Yes No

2. Name of Employing Company _____

Work or office location _____

Signature of Company Representative _____ Title _____ Date _____