CONSOCIATE HEALTH

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 _____