



CONSOCIATE • DANSIG

# Disabled Dependent Certification

## TO BE COMPLETED BY EMPLOYEE

1. Name of Employee: (print) Last			First	Middle Initial	BlueCross BlueShield Numbers (Group/Subscriber)
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2. Employee's Address: Number		Street	City	State	Zip Code
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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 Occured

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 Signed

## TO BE COMPLETED BY ATTENDING PHYSICIAN Note: Any fee for the completion of this form is the responsibility of the employee.

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. Diagnosis 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's Signature	Date
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Address of Physician (print of 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