



GROUP - 23 MENTALLY OR PHYSICALLY DISABLED DEPENDENT CERTIFICATION

TO BE COMPLETED BY SUBSCRIBER		
1. Subscriber's name (last, first, middle initial)	1a. Group & identification number	
2. Subscriber's address (number, street, city, state, zip code)		
3. Name of dependent child	3a. Child's birth date Month Day Year	3b. Child's marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
3c. Child's relationship to you	3d. Child's sex <input type="checkbox"/> Male <input type="checkbox"/> Female	3e. Child's age when disability occurred
5. Is child dependent upon you for support? <input type="checkbox"/> Yes <input type="checkbox"/> No	5a. If "Yes", what part of support do you contribute?	
6. Was child ever employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	6a. Is child employed now? <input type="checkbox"/> Yes <input type="checkbox"/> No	6b. If answer to 6 or 6a is "Yes", List name(s) and address(es) of employer(s) and date(s) employed in area 9 below.
7. Is child now covered under any other hospital-medical-surgical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	8. If answer to 7 is "Yes", furnish name of company and group certification or agreement number.	
9. Explanation of 6 or 6a	10. Is dependent now on Medicare or eligible in next six months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Medicare Number:	

I hereby certify that the above information is correct to the best of my knowledge and authorize release of any information requested with the respect to this Certification.

SIGNATURE OF SUBSCRIBER

DATE SIGNED

TO BE COMPLETED BY ATTENDING PHYSICIAN		
1. Is child now incapable of self-support because of a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. Has such disability existed continuously before child attained age 23? <input type="checkbox"/> Yes <input type="checkbox"/> No	3. Prognosis (estimate months or years)
4. Nature of Disability (Please provide as much detail as possible)		
Name of physician (print or type)	Physician's signature & date	
Address of physician (print or type)		