

# Disabled Dependent Certification

After completing Section A of this form, please forward this form along with the enclosed envelope to your physician for his or her completion



## Section A—Employee Information

Employee Last Name										Cal Choice 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" value="0"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
Employee First Name										Middle Initial			
<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 Social Security Number													
<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 Address					City					State		Zip	
Group Name			Dependent Name				Dependent Birth Date			Dependent Marital Status			
Does the dependent reside in your home?			Is he or she more than 50% dependent upon you for support?				Is he or she listed as dependent on your last income tax return?						
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No						
Is dependent employed?					If yes, date of hire			Number of hours employed per week					
<input type="checkbox"/> Yes <input type="checkbox"/> No													
Describe nature of duties													
<p><b>I certify that the above information is correct and authorize the release of medical information requested with respect to this certification</b></p> <p style="text-align: center;"><b>X</b></p> <p style="text-align: center;">_____</p> <p style="text-align: center;">SIGNATURE OF SUBSCRIBER <span style="float: right;">DATE</span></p>													

## Section B—To be completed by attending physician

<p><i>An unmarried 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.</i></p> <p>Please give us the specifics as to the nature of the disability (attach supporting documentation)</p>  			
<p>To what extent does the disability limit normal activity? (attach supporting documentation)</p>  			
<p>What is your prognosis, including your estimates of length of time this disability may be expected to continue? (attach supporting documentation)</p>  			
Physician signature		Name of physician	
Address		Date signed	
City		State	
Zip			