



# DISABLED DEPENDENT CERTIFICATION

**MUST BE COMPLETED BY THE SUBSCRIBER**

**Please return the completed form in a sealed envelope to your Human Resources Representative  
The envelope should be forwarded to the Blue Cross Sales Office**

<b>After completing the following section, please forward this form to your physician for his completion.</b>			
1. Subscriber's Name (Last, First, Middle Initial)		1a. Identification Number	
2. Home Address (Number, Street, City, State and Zip Code)			
3. Employer Group Name		Employer Group Address:	
4. Dependent's Name		4a. Dependent's Birth Date	4b. Dependent's Marital Status
5. Does the dependent qualify to be claimed on your federal income tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No			
6. Is dependent employed?		6a. Date of Hire	6b. Number of hours employed per week.
6c. Describe nature of duties.			
I certify that the above information is correct and authorize the release of medical information requested with respect to this certification.			
_____		_____	
Signature of Subscriber		Date Signed	

## TO BE COMPLETED BY ATTENDING PHYSICIAN

1. Please give us specifics as to the nature of the disability.		
2. To what extent does the disability limit normal activity		
3. What is your prognosis including your estimates of length of time this disability may be expected to continue?		
Name of Physician	Physician's Signature	Date Signed
Address of Physician		