

# Evidence of Dependent Disability and Support

Name of Policy Holder		Group Number
Member Name		Member Social Security Number
Member Address (street, city, state, zip) _____ _____ _____		
Dependents Name		Relationship to Member
Dependents Address (if same as member address indicate 'same') _____ _____ _____		
Dependents Birth Date		Date Dependent's Disability Began
Cause of Dependents Disability		
Have you supported your dependent from the date of disability to the present date?  Yes _____ No _____	Indicate the percentage of support you furnish for the dependent  _____ %	Do you take this child as an exemption for income tax purposes?  Yes _____ No _____
Last date on which dependent performed work, if any, and dependents occupation at that time:	Dates:	Occupation:
Name and address of dependent's employer: _____ _____ _____		
Name and address of any other physician(s) consulted since this disability began: _____ _____ _____		

Member's Signature

Date

Note: The member is responsible for the completion of this form without expense to Great-West Healthcare

## Attending Physician's Statement of Disability

Dependent's Name
Dependent's address _____ _____

### History

When did the present illness or mental condition begin, or when did injury occur?	Date dependent ceased work (if applicable)?	Is there a previous history of this illness or mental condition? Yes _____ No _____
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### Present Condition

Subjective symptoms (please describe) _____ _____
Objective findings (check all categories applicable to this dependent) <input type="checkbox"/> Ambulatory <input type="checkbox"/> Bed Confined <input type="checkbox"/> House Confined <input type="checkbox"/> Hospital Confined

### Diagnosis

Please provide your diagnosis of this dependent's condition _____ _____
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### Treatment

Date of first visit	Date of last visit	Frequency of visits	When did you last examine the dependent?
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### Progress

Please check the appropriate box: <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unimproved <input type="checkbox"/> Retrogressed
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### Degree of Disability

Is dependent totally disabled and unable to do any work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If still totally disabled, when do you think the dependent will be capable of self-supporting work? Approximate date _____ <input type="checkbox"/> Indefinite <input type="checkbox"/> Never	If no longer totally disabled, when was the dependent capable of self-supporting work? (provide month/day/year) Date _____
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Physician's Signature	(Include Degree)	Date
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Address (street, city, state, zip)

# Activities of Daily Living

Use another sheet if necessary

Name:	Certificate #
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## GENERAL

Please describe your current medical condition and any progress you believe you have made since you stopped working:

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List all your medical problems that you see a doctor for:

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List the name and address of all physicians, facilities and/or other providers that are providing medical care for you:

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List all medications you are currently taking together with their dosage and frequency:

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Do you live alone?  Yes  No      Are you married?  Yes  No

If you are married, does your spouse work?  Yes  No

If yes, what is spouse's occupation \_\_\_\_\_?

Do you have dependent children?  Yes  No      If yes, state their names and dates of birth:

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What is your height? \_\_\_\_\_ Your weight? \_\_\_\_\_ lbs.

Check your highest lever of formal education:

Elementary school 1 2 3 4 5 6 7 8      Secondary school 9 10 11 12      GED

College: Where \_\_\_\_\_ Degree?  Yes  No      Dates: \_\_\_\_\_ Type: \_\_\_\_\_

SELF CARE – personal hygiene, dressing, etc.      Assistance Required?  Yes  No

Explanation and Comments: \_\_\_\_\_

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## Activities of Daily Living

### HOUSEHOLD CARE

Is additional help or assistance needed? How often?

Cleaning/maintenance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Cooking	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Errands	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Miscellaneous (Repairs, yard work, pets, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly

Explanation and Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SOCIAL INTERACTIONS – Have you experienced any changes? How frequently do you visit, telephone or participate?

With Family	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
With Friends	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Activity Groups	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly

Explanation and Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **Activities of Daily Living**

Related to any of the above activities, what enables or prevents you from being able to perform them? Where you need assistance, how long have you needed this?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please give a general description of your regular day from morning through bedtime:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please attach/include any additional information you feel is pertinent.

Member's Signature

Date