



APPLICATION FOR DISABLED DEPENDENT

SECTION 1 – To be completed by subscriber					
Subscriber's Last Name			First		Group Name
Home Address		City	Zip Code	Home Phone Number	Group Number
Dependent's Last Name		Relationship to Subscriber		Birthdate of Dependent Mo. Day Year	
Is dependent currently Enrolled in the health plan? <input type="checkbox"/> YES <input type="checkbox"/> NO		If no, reason not enrolled			
Was or is dependent Employed for wages? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, give name and address of employer			Average Weekly Earnings
If no longer working, give reason for termination →				Does dependent qualify as Your income tax deduction? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Signature of Subscriber				Date Signed	

SECTION 2 – To be completed by physician					
Is dependent presently incapable of self-sustaining employment because of: <input type="checkbox"/> mental capacity <input type="checkbox"/> physical handicap				When did this disability occur?	
Diagnosis of condition causing disabled status and description of limitations _____ _____ _____ _____					
In your opinion, will the dependent ever be Capable of self sustaining employment? <input type="checkbox"/> YES <input type="checkbox"/> NO		Is disability? <input type="checkbox"/> Temporary <input type="checkbox"/> Continuing		Is disability likely to improve? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Additional Remarks _____ _____ _____					
Name of Attending Physician		Address		City	Zip Code
Signature of Physician			Telephone number		Date signed

Instructions

- 1) Subscriber to complete Section 1 and have Section 2 completed by dependent's attending physician.
- 2) Physician, please complete form, giving pertinent information which will enable us to evaluate the extent and anticipated duration of dependent's disability.
- 3) Completed form to be forwarded to Membership Accounting Department, PO Box 921010, Fort Worth, TX 76121.