USAble Life Group Health

PROOF OF INCAPACITY OF A DEPENDENT

EMPLOYEE'S INFORMATION

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	GROUP NAME	GROUP NUMBER
	___-___-____		

HOME ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBERS

HOME	WORK	OTHER NUMBER

DEPENDENT'S NAME	SOCIAL SECURITY NUMBER	DEPENDENT'S BIRTHDATE			RELATIONSHIP TO EMPLOYEE
		MO.	DAY	YR.	
	___-___-____				

SEX: ☐ MALE ☐ FEMALE	DATE CONDITION COMMENCED	PROBABLE DURATION OF CONDITION

CIRCLE LAST YEAR OF SCHOOL COMPLETED

1 2 3 4 5 6 7 8 9 10 11 12 COLLEGE 1 2 3 4

IS CHILD A STUDENT NOW? ☐ YES ☐ NO	IF YES, WHERE?

I certify that the above information is true and correct and that the dependent listed above is, by reason of mental retardation or physical handicap, residing with me and solely dependent upon me for support and maintenance.

_____ _____

EMPLOYEE SIGNATURE **DATE (Month Day Year)**

PROOF OF INCAPACITY OF A DEPENDENT (To be completed by the physician)

_____, contract #_____ has applied for coverage of his/her son/daughter, _____, on his/her contract. USAble Life has a provision for covering severely incapacitated dependents on an exception basis. In order for us to make a determination, please complete this sheet and attach any supporting documentation which provides following information:

- Current age, height, and weight
- Description of any significant acute or chronic condition
- Age at onset of condition
- Medications, including frequency and dosage
- Any related health problems
- Any current or future health consideration
- Other important facts

Most of the above can be satisfied by a copy of the patient's file and/or discharge papers if there was a recent hospitalization.

Comments:

_____

_____

Date the above name dependent became incapacitated: _____
Month Day Year

Date the above named dependent is expected to be capable of being employed. _____
Month Day Year

I have examined the dependent named above, and the degree of his/her disability is of such a nature that he/she would be incapable of sustaining employment.

Physician Name _____

Physician Address _____

Physician Signature _____