

## Application for Disabled/Handicapped Dependent

Employee Name:  
Employee Address:

Group Number:  
Name of Employer:

Employee Social Security #  
Dependent's Name:  
Address:

Date of Birth:

In order to consider the above captioned dependent for continuation of coverage as an eligible dependent, please provide the following information:

1. Nature of disabling illness or injury?
2. What is the date the disability began?
3. Is the disability related to Worker's Compensation?    Yes    No  
If yes, with whom?
4. Is the dependent now wholly unable to work?    Yes    No
5. Does this individual reside with you on a permanent basis?    Yes    No  
If yes, since when (date)  
If no, please explain
6. Are you legally responsible for the individual's medical expenses?    Yes    No
7. Upon whom is this individual dependent on for primary care and support?
8. Is this dependent in regular full-time attendance at an accredited school or institution of learning?    Yes    No  
If yes, please provide name of school:  
Address:  
Date of Attendance:
9. Does the dependent have any other medical insurance at this time?    Yes    No
10. Is the dependent currently working?    Yes    No  
If yes, please provide company name, address, and phone number:
11. What is the current prognosis of the disability?
12. What is the name and address of the handicapped/disabled dependent's physician?

**A Health Statement and an Authorization to Obtain and Disclose Information must be also completed, signed, dated and returned to us within this questionnaire.**

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date