CaliforniaChoice®
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(800) 558-8003 • www.calchoice.com

Disabled Dependent Certification

After completing Section A, please forward this form to your physician for his or her completion

SECTION A - Employee Information

Company Name

Group #

Employee Last Name

Employee Social Security #

Employee First Name

M.I.

Employee Address

Apt. #

City

State

ZIP Code

Dependent Last Name

Dependent First Name

Date Disabling Condition Occurred (MM/DD/YYYY)

Dependent Date of Birth (MM/DD/YYYY)

Dependent Marital Status

Does the dependent reside in your home? ☐ Yes ☐ No

Is he or she more than 50% dependent upon you for support? ☐ Yes ☐ No

Is he or she listed as dependent on your last income tax return? ☐ Yes ☐ No

Is dependent employed? ☐ Yes ☐ No

If yes, date of hire (MM/DD/YYYY)

Number of hours Employed per week

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

Employee Signature **Print Name** **Date (MM/DD/YYYY)**

SECTION B - To be completed by attending physician

A dependent child who is incapable of self-support due to a continuously disabling illness or injury may be continued as a family member on the parent's health coverage. Your medical statement will help us determine the eligibility of this dependent.

Please give us the specifics as to the nature of the disability (attach supporting documentation)

To what extent does the disability limit normal activity? (attach supporting documentation)

What is your prognosis, including your estimates of length of time this disability may be expected to continue? (attach supporting documentation)

Physician Signature **Print Name** **Date (MM/DD/YYYY)**

Address **City** **State** **ZIP Code**

56033

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