Disabled Dependent Certification

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

Section A—Employee Information

Employee Last Name

Group #

Employee First Name

Middle Initial

Employee Social Security Number

Group Name			
Employee Address	City	State	Zip
Date Disabling Condition Occurred	Dependent Name	Dependent Birth Date	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	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

X _____ _____

SIGNATURE OF SUBSCRIBER DATE

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	Name of physician		Date signed
Address	City	State	Zip