DISABLED DEPENDENT CERTIFICATION

TO BE COMPLETED BY THE SUBSCRIBER

After completing the following section, please forward this form along with the enclosed envelope to your physician for his completion.

1. Subscriber's Name (Last, First, Middle Initial)		1a. Identification Number
2. Home Address (Number, Street, City, State and Zip Code)		
3. Group Name		3a. Group Number
4. Dependent's Name	4a. Dependent's Birth Date	4b. Dependent's Marital Status

5. Does the Dependent reside in your Home? ☐ Yes ☐ No	6. Is he/she more than 50% dependent upon you for support? ☐ Yes ☐ No	7. Is he/she listed as dependent in your last Federal Income Tax Return? ☐ Yes ☐ No

8. Is dependent employed?	8a. Date of Hire	8b. Number of hours employed per week.
8c. 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.

_____ _____

Signature of Subscriber Date Signed

TO BE COMPLETED BY ATTENDING PHYSICIAN

An unmarried 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 Blue Cross Contract. Your medical statement will help us to determine the eligibility of this dependent.

Please return the completed form to:

Banyan Administrators, LLC
Managers for the CalCPA Health program
1215 Manor Drive, Suite 200
Mechanicsburg, PA 17055
Phone: 877-480-7923 Fax: 877-237-4519

1. List the ICD9 codes relevant to the disabling condition
2. Describe the disabling condition
3. To what extent does the disability limit normal activity
4. What is your prognosis including your estimates of length of time this disability may be expected to continue?

Name of Physician	Physician's Signature	Date Signed
Address of Physician		