Mentally or Physically Disabled Dependent Enrollment Request

TO BE COMPLETED BY DEPENDENT'S PARENT OR LEGAL GUARDIAN

Check coverage(s) that apply(ies): ☐Health ☐Dental ☐Vision ☐Life

Group Number _____ Entity/County Name_____

Employee Name_____ SSN_____

Address_____ City, State, Zip_____

Employee's Signature_____ Date_____

Dependent Child Name_____

Dependent Birthdate ___/___/_____ Dependent Marital Status_____

Was the dependent ever institutionalized? ☐No ☐Yes, give name and address of institution and period(s) of confinement
Is the dependent eligible for care or coverage under Federal, State or Local Law? ☐No ☐Yes, give details
Is, or was, the dependent employed for wages? ☐No ☐Yes, give name and address of current or last employer and average weekly earnings
If the dependent is no longer employed, give reason for termination
Is the dependent financially dependent on the employee? ☐No ☐Yes

TO BE COMPLETED BY DEPENDENT'S PHYSICIAN ONLY

Dependent is presently incapable of self-sustaining employment by reason of: ☐Mental Disability ☐Physical Disability
Is the disability congenital? ☐No ☐Yes
In your opinion, will dependent ever be capable of self-sustaining employment ☐No ☐Yes
Diagnosis of condition causing disability status
Remarks (Provide as much detailed information that you believe may be beneficial in this matter. Attach additional documentation as applicable)

Physician's Name_____

Address_____ City, State, Zip_____

Physician's Signature_____ Date_____