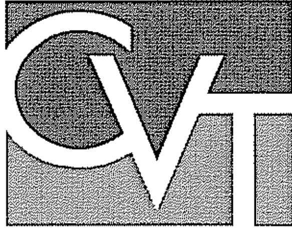

CALIFORNIA'S VALUED TRUST

Healthcare Benefits for the Education Community

520 EAST HERNDON AVENUE · FRESNO, CA 93720 · 559-437-2960 · 800-288-9870 · FAX 559-437-2965 · WWW.CVTRUST.ORG

DISABLED DEPENDENT CERTIFICATION REQUEST

TO BE COMPLETED BY THE SUBSCRIBER

Subscriber's Name	Subscriber's Address **(Please check if new address ☐)**
Subscriber's Social Security Number	Subscriber's Employer

Dependent's Name		
Dependent's Marital Status ☐ Single ☐ Married	Dependent's Gender ☐ Male ☐ Female	Dependent's Date of Birth ______ Dependent's SSN ______
My son/daughter was listed as a dependent on my last tax return	☐ Yes	☐ No

SUBSCRIBER'S SIGNATURE ______________________ **DATE SIGNED** ______________

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

A dependent child who is incapable of self-support due to MENTAL or PHYSICAL handicap may be eligible for continued coverage as a disabled dependent. Your medical statement will help us determine the above named dependent's eligibility. Please attach any additional information you feel is needed.

1. Please give the diagnosis, specifics, and describe your patient's mental or physical handicap in detail.

____

____

2. Is the patient incapable of self-sustaining employment by reason of mental or physical handicap? If yes, to what extent does the disability limit normal activity?

____

____

3. What is your prognosis, including your estimated length of time this disability is expected to continue?

____

Physician's Name	Physician's Signature	Date Signed

Physician's Address	Physician's Telephone Number