



# 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 DEPENDANT CERTIFICATION REQUEST

### TO BE COMPLETED BY THE SUBSCRIBER

Subscriber's Name	Subscriber's Address (Please check if new address <input type="checkbox"/> )
Subscriber's Social Security Number	Subscriber's Employer

Dependant's Name		
Dependant's Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Dependant's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Dependant's Date of Birth _____  Dependant's SSN _____
Does the dependant rely on the subscriber and/or subscriber's spouse to contribute at least 50% of the cost of the dependant's support and maintenance (defined as customary living expenses such as housing, transportation, food, medical care, clothing etc.)?		<input type="checkbox"/> Yes <input type="checkbox"/> No

**SUBSCRIBER'S SIGNATURE**

**DATE SIGNED**

### TO BE COMPLETED BY THE ATTENDING PHYSICIAN

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

1. List the ICD9 codes relevant to the disabling condition: \_\_\_\_\_

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

3. 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?

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

Physician's Name	Physician's Signature	Date Signed
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Physician's Address	Physician's Telephone Number
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