Employee / Physician Statement Incapacitated Dependent Form

Employee's statement

Employee name	Social Security number	Group name	Group number
	- -		

Home address	City	State	ZIP

Primary phone number	Work phone number	Email

Dependent's name	Social Security number	Dependent's birthdate	Relationship to employee
	- -	/ /	

Sex	Date condition commenced	Probable duration of condition
☐ Male ☐ Female	/ /	

Highest level of education completed	Is child a student now?	If yes, where?
	☐ Yes ☐ No	

I certify the above information is true and correct and the dependent listed above is by reason of intellectual or physical disability, residing with me and chiefly dependent upon me for support and maintenance.

Employee signature	Date (Month / Day / Year)
	/ /

Physician's Statement (To be completed by the physician)

Diagnosis or description of the condition of the above dependent which does not permit employment.
(If additional space is needed, please use back of form.)

Date the above named dependent became incapacitated (Month / Day / Year)	Date the above named dependent is expected to be capable of being employed (Month / Day / Year)
/ /	/ /

I have examined the dependent named above and the degree of his or her disability is of such a nature that he or she would be incapable of sustaining employment.

Signature of physician	Date (Month / Day / Year)
	/ /

Address of physician	City	State	ZIP

Submission of this form is not a guarantee of coverage and is subject to approval by the plan administrator.

Please return this signed form to:
ATTN: Corporate Medical Director Division | P.O. Box 2181 Little Rock, AR 72203-9974
Fax: 501-399-3967 | **Email:** CMDIncapacitatedDepReq@skaibluecross.com