Disabled Dependent Certification

After completing Section A, please forward this form to your physician for his or her completion

ChoiceBuilder®
721 South Parker, Suite 200 • Orange, CA 92868
(866) 412-9279
www.choicebuilder.com

Section A—Employee Information

Employee Last Name

Group # B

Employee First Name

M.I.

Employee Social Security #

Company Name			
Employee Address	City	State	ZIP Code
Date Disabling Condition Occurred (MM/DD/YYYY)	Dependent Name	Dependent Date of Birth (MM/DD/YYYY)	Dependent Marital Status
Does the dependent reside in your home? ❑ Yes ❑ No	Is he or she more than 50% dependent upon you for support? ❑ Yes ❑ No	Is he or she listed as dependent on your last income tax return? ❑ Yes ❑ No	
Is dependent employed? ❑ Yes ❑ No	If yes, date of hire (MM/DD/YYYY)	Number of hours employed per week	
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

X _____ _____

Employee Signature | Date (MM/DD/YYYY)

Section B—To be completed by attending physician

A 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 health coverage. Your medical statement will help us determine the eligibility of this dependent.

Please give us the specifics as to the nature of the disability (attach supporting documentation)

To what extent does the disability limit normal activity? (attach supporting documentation)

What is your prognosis, including your estimates of length of time this disability may be expected to continue? (attach supporting documentation)

Physician Signature	Print Name of physician		Date (MM/DD/YYYY)
Address	City	State	ZIP Code

CB 0440 10/2019
License # 0N14196 – ChoiceBuilder Insurance Services