Dependent Disability Verification Form

To Be Completed by the Subscriber:

After completing the following section, please forward this form along to your physician for his or her completion.				
1. Last Name:	First Name:	M.I.:	1a. Identification Number:	
2. Home Address:	City:		State:	ZIP Code:
3. Group Name:			3a. Group Number:	
4. Dependent's Name:	4a. Dependent's Birth Date:		4b. Dependent's Marital Status:	
5. Does the dependent qualify to be claimed on your federal income tax return? ☐ Yes ☐ No				
6. Is dependent employed? ☐ Yes ☐ No	6a. Date of Hire:		6b. Number of hours employed per week:	
6c. 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. _____ Subscriber's Signature _____ Date Signed				

To Be Completed by the Attending Physician:

An unmarried 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 MotivHealth Insurance Contract. **Please return the completed form along with supporting documents/medical records.**			
1. List the ICD9 codes relevant to the disabling condition:			
2. Describe the disabling condition:			
3. To what extent does the disability limit normal activity?			
4. What is your prognosis, including your estimates of length of time this disability may be expected to continue?			
Physician's Name:	Physician's Signature:		Date Signed:
Physician's Address:	City:	State:	ZIP Code: