



# HANDICAPPED / DISABLED DEPENDENT DETERMINATION

P.O. Box 4445  
Atlanta, GA 30302  
Fax: 404-842-8040



**Contract holder must fill in all fields on the application or it will not be processed.**

Full Name of Contract Holder (Last, First, Middle)			Group Number	Contract Number		
Mailing Address		City	State	Zip Code	Telephone Number	
Full name of handicapped/disabled dependent (Last, First, Middle)		Birthdate	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security No. of Dependent	
Marital Status of Dependent <input type="checkbox"/> Married <input type="checkbox"/> Single	Relationship To Contract Holder		Nature of Disability			Date of Disability
Is dependent listed as Income Tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No			Was or is dependent employed for wages? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Dependent (s) last Employer		Address of Dependent (s) last Employer (Street, City, State, Zip Code)			Average Weekly Earnings	
Reason for Termination			Termination Date	Does dependent now have any Hospital/Medical coverage? If "Yes", complete details below. <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>OTHER INSURANCE POLICIES PROVIDING FOR DISABILITY, SICKNESS OR ACCIDENT BENEFITS FOR THE DEPENDENT</b>						
Company Name		Address (Street, City, State, Zip Code)			Policy or Certificate Number	
Is dependent eligible for care under Federal, State or Local Law? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes", give type of care		Address of agency providing care (Street, City, State, Zip Code)		
Is dependent currently receiving Social Security benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			If "Yes", what was the effective date?		If "No", have benefits been denied? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>THE FOLLOWING MUST BE COMPLETED AND CERTIFIED BY A PHYSICIAN</b>						
1. The above named dependent is presently incapable of self-sustaining employment by reason of (Check One) <input type="checkbox"/> Mental Handicap <input type="checkbox"/> Physical Handicap <input type="checkbox"/> Total Disability					Is handicap congenital? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Diagnosis of condition(s), illness or injury causing status checked in Number 1 above (Describe fully the nature of the disability)					Mo.	Date of Disability Day
Name of Disabling Diagnosis						
ICD-9 Code(s)						
3. Prognosis and estimated number of months or years						
4. Was dependent hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of hospital, if admitted as an inpatient				
Admitted (Mo., Day, Year)	Discharged (Mo., Day, Year)	Address of hospital (Street, City, State, Zip Code)				
Admitting Diagnosis					ICD-9 Code	
Date dependent became totally and continuously disabled and completely prevented from engaging in any occupation whatsoever for compensation					Mo.	Day
Has dependent been able to engage in any gainful occupation or do any work since the disability began? <input type="checkbox"/> Yes <input type="checkbox"/> No			Date dependent resumed work or expects to resume work		Mo.	Day

