

Request for Certification of Disabled Dependent



Employee Instructions:

- Complete all sections on this form.
- Ask your physician to complete the attending physician's statement and return the form to you.
- Return the completed form to CGHC:

Fax: (262) 754-9560 Attn: Sales | Mail: CGHC Attn: Sales, PO Box 1630, Brookfield, WI 53008-1630 | Email: Sales@CommonGroundHealthcare.org

Employee Information

CGHC Member #		CGHC Group #	
Employee Name (last name, first name, M.I)			
Employee Address (including City, State, Zip Code)			
Dependent's Name		Dependent's Birthdate	Dependent's Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Dependent's Relationship to Employee <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other (explain):		Dependent's Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Dependent's Age when Disability Occurred:
A. Is this dependent covered by Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please list his/her SSN:	
B. Do you support this dependent?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, what amount? _____ %	
C. Does this dependent reside with you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If No, why?	
D. Dependent address if different than subscriber: _____			
E. Does this dependent chiefly rely on you for support and maintenance?			<input type="checkbox"/> Yes <input type="checkbox"/> No
F. If this dependent is 18 or older, has a court appointed you his/her legal guardian?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, attach copy of documentation.	

I Certify that this information is correct to the best of my knowledge.

Policyholder Signature X	Date Signed
-----------------------------	-------------

Physician* - Complete Below

Any fee for the completion of this form is the responsibility of the policyholder.

Physician Name		Degree	
Street Address	City	State	ZIP Code
A. Is dependent above incapable of self-sustaining employment due to disability?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>B. Nature of Disability: Please attach a letter to address the following items using as much detail as possible. Also attach medical records pertaining to the disability within the past 12 months (to include the most recent complete physical, functional and communicative evaluative documentation, laboratory and clinical findings).</p> <ul style="list-style-type: none"> • ICD Code(s) that is/are the handicapping condition: _____ • Identify the current treatment for identified symptoms and functional impairments. • Is the disability temporary or permanent? <input type="checkbox"/> temporary <input type="checkbox"/> permanent <ul style="list-style-type: none"> ▪ If temporary, what is the estimated time frame for the disability? _____ ▪ If permanent, provide rationale for that status. • Please provide a description of specific symptoms and functional impairments that render the individual disabled. Please also provide supporting documentation including your most recent medical history and physical exam notes (must be within the past 12 months); functional assessments such as activities of daily living, education/ employment capabilities, etc; results of any specialized testing including laboratory tests, functional capacity tests, neuropsychiatric tests, etc.; as well as treatment prescribed and prognosis. 			
Signature of Physician		Date Signed	Date of last evaluation

Please Note: knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

*Examples of acceptable sources for the Physician information include: licensed physicians or optometrists, and licensed or certified psychologists