Proof of Incapacity of a Dependent

SUBSCRIBER'S FORM

Subscriber Name ______________________________ Subscriber # ____________________

Subscriber SSN ______________________________ Home Phone ____________________

Address ______________________________ Work Phone ____________________

Group Name ______________________________ **Group Number** ____________________

Dependent Name ______________________________ Dependent SSN ____________________

Sex: ❑ Male ❑ Female Date of Birth ____________ Relationship to Subscriber ____________________

Primary Care Physician ______________________________ Date Disability Began ____________________

Indicate which activities the dependent is able to perform without assistance:

Yes	No	Activity
		Dress Self
		Bathe
		Walk
		Cook Meals
		Housework

Yes	No	Activity
		Manage Finances
		Drive
		Be Employed
		Manage Medications
		Shop for Food/Necessities

Is dependent covered by any other health insurance, including Medicare or Medicaid? ❑ Yes ❑ No

If yes, give policy numbers, effective date, name and address of other insurance company and name in which policy is held: ______________________________

I certify that the above information is true and correct and that the dependent listed above is incapable of self care/self support, by reason or mental retardation or physical incapacity.

______________________________ ____________________

Subscriber Signature Date

______________________________ ____________________

Group Administrator Signature (if new member) Date

Arkansas Blue Cross and Blue Shield
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