



Date _____

Dependent Child's Statement of Disability

Group No. _____ Identification No. _____

Employee's Name _____

Employee's Address _____
Street Address City State ZIP Code

Dependent Child's Name _____

Social Security No. _____ Relationship _____

Dependent Child's Place of Residence/Address _____
Street Address

City State ZIP Code

Marital Status _____

Date of Birth _____

I hereby authorize any hospital, physician or health care provider who has treated the above dependent child to furnish medical information that is specific to the dependent's disability to Blue Cross and Blue Shield of Texas and HMO Blue® Texas. This authorization will expire one year after the employee's signature date.

Signature of Employee _____ Date _____

TO BE COMPLETED BY ATTENDING PHYSICIAN

NOTE: Any fee for the completion of this form is the responsibility of the patient.

1. Patient's Name _____

2. Diagnosis (Be as detailed as possible) _____

3. If dependent child has ever been under observation, care or treatment related to the dependent's disability in any hospital, sanitarium, asylum or similar institution, please complete the following:

Name of hospital or institution _____

Number of days _____ Date of last treatment or care _____

4. Treatment (a) Date of first visit _____
(b) Frequency of visits Weekly () Monthly ()
Other ()

5. Extent of Disability
(a) Is patient now incapable of self-support because of disability? Yes () No ()
(b) Disability has existed continuously since _____
(c) When do you think patient will be able to return to gainful employment?
Approximate Date _____ Indefinite _____ Never _____

Name of Physician _____ Phone _____

Address of Physician _____
Street Address City State ZIP Code

Physician's Signature _____ Date _____