CALIFORNIA'S VALUED TRUST
Healthcare Benefits for the Education Community

520 East Herndon Avenue □ Fresno, CA 93720 □ 559-437-2960 □ 800-288-9870 □ Fax 559-437-2965 □ www.cvtrust.org

DISABLED DEPENDANT CERTIFICATION REQUEST

TO BE COMPLETED BY THE SUBSCRIBER

Subscriber's Name	Subscriber's Address **(Please check if new address ☐)**
Subscriber's Social Security Number	Subscriber's Employer

Dependant's Name		
Dependant's Marital Status ☐ Single ☐ Married	Dependant's Gender ☐ Male ☐ Female	Dependant's Date of Birth _____ Dependant's SSN _____
Does the dependent rely on the subscriber and/or subscriber's spouse to contribute at least 50% of the cost of the dependent's support and maintenance?	☐ Yes	☐ No

SUBSCRIBER'S SIGNATURE **DATE SIGNED**

_____ _____

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

A dependant child who is incapable of self-support due to MENTAL or PHYSICAL handicap may be eligible for continued coverage as a disabled dependant. Your medical statement will help us determine the above named dependant's eligibility. Please attach any additional information you feel is needed.

1. Please give the diagnosis, specifics, and describe your patient's mental or physical handicap in detail.

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2. Is the patient incapable of self-sustaining employment by reason of mental or physical handicap? If yes, to what extent does the disability limit normal activity?

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3. What is your prognosis, including your estimated length of time this disability is expected to continue?

_____

Physician's Name	Physician's Signature	Date Signed

Physician's Address	Physician's Telephone Number