DISABLED DEPENDENT APPLICATION

TO BE COMPLETED BY SUBSCRIBER/PLAN PARTICIPANT

It is important to complete the application in full.

Incomplete or omitted information may result in the application being delayed or returned to you.

1. NAME OF SUBSCRIBER (PRINT LAST, FIRST, MIDDLE INITIAL)	2. IDENTIFICATION NUMBER	3. GROUP NUMBER

4. ADDRESS (NUMBER, STREET, CITY, STATE AND ZIP CODE)

5. NAME OF DEPENDENT CHILD	6. CHILD'S DATE OF BIRTH MO DAY YR	7. CHILD'S RELATIONSHIP TO SUBSCRIBER

8. CHILD'S SEX: ☐ MALE ☐ FEMALE	9. CHILD'S MARITAL STATUS: ☐ S ☐ M	10. DATE CHILD'S DISABILITY OCCURRED

DESCRIBE YOUR CHILD'S DISABILITY

11. IS CHILD PERMANENTLY RESIDING IN YOUR HOUSEHOLD? ☐ YES ☐ NO	PLEASE EXPLAIN:

12. IS CHILD PRIMARILY DEPENDENT UPON YOU FOR FINANCIAL SUPPORT? ☐ YES ☐ NO

13. PLEASE ESTIMATE THE PERCENTAGE OF FINANCIAL SUPPORT THAT YOU PROVIDE FOR YOUR CHILD. _____%

14. DO YOU CLAIM THIS CHILD AS YOUR DEPENDENT FOR FEDERAL INCOME TAX REPORTING? ☐ YES ☐ NO

15. IS THIS CHILD RECEIVING SOCIAL SECURITY INCOME? ☐ YES ☐ NO IF YES, WHAT MONTHLY AMOUNT? $ _____

16. WAS CHILD EVER EMPLOYED? ☐ YES ☐ NO	17. IS CHILD EMPLOYED NOW? ☐ YES ☐ NO

18. IF ANSWER TO #16 IS 'YES', PLEASE GIVE NAME(S) AND ADDRESS(S) OF EMPLOYER(S) AND DATE(S) EMPLOYED BELOW. ALSO HOURS WORKED PER WEEK AND CURRENT HOURLY WAGE. _____

_____

19. IS CHILD A STUDENT? ☐ YES ☐ NO FULL TIME OR PART TIME?_____	IF 'YES', WHERE IS CHILD ATTENDING SCHOOL?_____ ANTICIPATED GRADUATION DATE _____ HOW MANY CREDITS IS YOUR CHILD TAKING?_____

X

SIGNATURE OF SUBSCRIBER/PLAN PARTICIPANT | DATE | PREFERRED PHONE NUMBER | ALTERNATIVE PHONE NUMBER

THIS PORTION OF THE APPLICATION TO BE COMPLETED BY ATTENDING PHYSICIAN

1. NAME OF PHYSICIAN (PLEASE PRINT)	2. ADDRESS

3. DIAGNOSIS AND HISTORY OF THE CONDITION (DO NOT PROVIDE ANY GENETIC INFORMATION, INCLUDING FAMILY MEDICAL HISTORY INFORMATION):

4. DATE OF ONSET:	5. MOST RECENT DATE OF SERVICE:

6. CURRENT TREATMENT PLAN, INCLUDING FOLLOW-UP AND MEDICATIONS:

7. DO YOU CONSIDER THIS CONDITION A DISABILITY?

8. DOES THE PATIENT'S CONDITION PREVENT HIM OR HER FROM EARNING A LIVING? IF 'YES', WHAT SPECIFIC LIMITATIONS DOES THE CONDITION IMPOSE?

9. IF NOT EMPLOYED FULL TIME, DOES THE CONDITION LISTED ABOVE PREVENT THIS PATIENT FROM WORKING FULL TIME?

10. HOW LONG WOULD THIS CONDITION BE EXPECTED TO CONTINUE?

X

SIGNATURE OF PHYSICIAN | DATE | PHONE NUMBER

Attending Physician - please return form directly to: COMPREHENSIVE CARE SERVICES, INC., P.O. BOX 64668, ST. PAUL, MINNESOTA 55164-0668