Proof of Incapacity of a Dependent | Policyholder

Policyholder name			Policyholder ID number	
Policyholder SSN - -	**Home phone**		**Work phone**	
Address	**City**	**State**	**ZIP**	
Group name			**Group number**	
Dependent name	**Dependent SSN** - -	**Sex** Male Female	**Date of birth**	**Relationship to policyholder**
Primary care physician		**Date disability began**		

Indicate which activities dependent perform or not perform without assistance

Yes	**No**	Dress self	**Yes**	**No**	Housework	**Yes**	**No**	Shop for food/necessities
Yes	**No**	Bathe	**Yes**	**No**	Manage medications	**Yes**	**No**	Be employed
Yes	**No**	Walk	**Yes**	**No**	Manage finances	**Yes**	**No**	Drive
Yes	**No**	Cook meals						

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 of intellectual and developmental disability or physical disability.

Policyholder signature	Date
Group Administrator Signature (if new member)	**Date**

Please return this signed form to:
ATTN: Corporate Medical Director Division
P.O. Box 2181
Little Rock, AR 72203-9974

Fax: 501-399-3967
Email: CMDIncapacitatedDepReq@arkbluecross.com

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