



HEALTH ADVANTAGE
Proof of Incapacity of a Dependent

THIS FORM MUST BE SUBMITTED TO HEALTH ADVANTAGE

To Be Completed by Subscriber

Subscriber Name Subscriber ID#

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 Percent of Financial Support by Subscriber

Last Grade Completed: 8 9 10 11 12 Special education classes yes no College 1 2 3 4

Dependent is Student Yes No Attends Special Program Yes No

Name/address of school/program

Indicate which activities dependent perform or not perform without assistance

Table with 3 columns: Yes, No, Activity. Activities include Dress self, Bathe, Walk, Cook meals, Housework, Manage medications.

Table with 3 columns: Yes, No, Activity. Activities include Manage finances, Drive, Attend School, Be employed, Use a computer, Shop for food/necessities.

Is dependent certified as disabled by Social Security Administration? Yes No

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, by reason of mental retardation or physical handicap, residing with me and solely dependent upon me for financial support and maintenance. (A copy of most recent Federal Income Tax return may be requested)

Subscriber Signature Date

Group Administrator Signature (if new member) Date

Please have the attached form completed by the Dependent's physician. Submit both forms:

Mail: Health Advantage Membership
P.O. Box 8069
Little Rock, AR 72203-8069

For Health Advantage Use Only
Approved Date
Annual Reverification required Yes No

# HEALTH ADVANTAGE

## Proof of Incapacity of a Dependent

*Must Be Completed by the Physician*

Subscriber Name \_\_\_\_\_ Subscriber# \_\_\_\_\_

Address \_\_\_\_\_

Dependent Name \_\_\_\_\_

Health Advantage covers dependent children that have reached the maximum dependent age that are physically or mentally incapacitated and incapable of self-support. In order for Health Advantage to make a determination, the following information must be completed. Please attach any supporting documentation.

Current age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Mental Incapacity \_\_\_\_\_ Physical Incapacity \_\_\_\_\_ Age at onset of condition/disability \_\_\_\_\_

Describe Incapacity or reason incapable of self care/self support \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Acute medical conditions (describe) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Chronic medical conditions (describe) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Future health concerns or considerations \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Medications, dosage, reason for medication \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Other important facts \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

A copy of any pertinent medical information may be attached.

I have examined the dependent named above, and the degree of his/her disability or incapacity is of such a nature that he/she is incapable of self care/self support.

\_\_\_\_\_  
Physician Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date