## **Proof of Incapacity of a Dependent | Physician's Form**

Policyholder name				Policyholder ID number				
Address		City			State			ZIP
The insurer covers d mentally incapacitat attach any supportin	ed. In order to m	ake a determin				-	_	
Dependent Name				Current age			Height	Weight
Mental incapacity Yes No	If Yes, add IQ score		Physical incapacity Yes No		city	Age at onset of condition/disability		ndition/disability
Describe incapacity	or reason incapal	ble of self care	/self sup	port				
Describe acute medi	cal conditions							
Describe chronic me	dical conditions							
Future health concer	rns or considerat	ions						
Medications, dosage	e, reason for med	ications						
Other important fact	ts							
A copy of any pertin	ent medical infor	rmation may be	e attache	ed.				
I have examined the nature that he/she is	•		_	ee of his	s/her d	isability	or incapacity	is of such a
Physician name			Sp	Specialty				
Physician signature			Da	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



