Employee's Name _____ Firm # _____ Certificate # _____

Dependent's Name _____ Employee's relation to the dependent _____

Dependent's Present Age _____ Dependent's date of birth (YYYY/MM/DD) _____

1. Is the over-age dependent financially dependent on you? ☐ Yes ☐ No
2. Is the disabled dependent eligible for:
   a) benefits under a government plan? ☐ Yes ☐ No
   b) health, dental or disability benefits from another source (e.g. spouse's plan)? ☐ Yes ☐ No

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Attending Physician Statement

To be completed by the disabled dependent's attending physician. The employee assumes responsibility for any costs associated w

Dependent Child's Name _____ Dependent Child's Birthdate (YYYY/MM/DD) _____

1. Onset date of disability

_____

2. Nature and degree of disability

_____

_____

_____

_____

3. Impairment or restrictions resulting from the condition

_____

_____

_____

_____

4. Is the dependent capable of working for remuneration or profit? ☐ Yes ☐ No

5. Prognosis of present condition. Is the condition permanent or can improvement be anticipated?

_____

_____

_____

_____

Physician Information

Name _____ Specialization _____

Address _____

Phone (____) _____

Signature _____ Date _____