CareFirst Administrators

DISABILITY CERTIFICATION

For an Over-age Dependent

Employer:	Subgroup:
Employee:	Identification Number:

Dependent Name:	Date of Birth:

I hereby certify that my son/daughter named above is unmarried, is disabled, and, because of health reasons, is incapable of self-support. I understand that his/her protection under my coverage will terminate according to the Summary Plan Description for my group.

_____ _____

Employee's Signature Date

Physician Name:	
Street Address:	
City, State, Zip:	Telephone Number:

I certify that I am a physician legally licensed to practice medicine in the State of _____.

I further certify that, in my medical opinion, the above-named dependent has been disabled and is incapable of self-support since _____. The nature of the disability is _____

_____

and, in my opinion, will be for _____ duration.

_____ _____

Physician's Signature Date

Please return completed form to:

CareFirst Administrators
PO Box 3900
Merrifield, VA 22116-3900

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