# Disability Certification For an Over-age Dependent

CareFirst Administrators

| EMPLOYEE/DEPENDENT INFORMATION | |
|---|---|
| Employer | Subgroup |
| Employee's Name | Identification Number |
| Dependent's Name | Dependent's Date of Birth |
| I hereby certify that my son/daughter named above, is unmarried, became disabled prior to his/her twenty-sixth (26th) birthday, 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 INFORMATION | | |
|---|---|---|
| Physician Name | Phone | |
| Street Address | | |
| City | State | ZIP |

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 |