

HEALTH PLAN DISABILITY CERTIFICATION

INSTRUCTIONS: Complete the Participant's side of this form. Have your doctor complete the reverse side of this form. Mail completed form to Claims Department at 3601 West Olive Avenue, PO Box 7830, Burbank, CA 91510-7830.

TOTAL DISABILITY DEFINED: *TOTAL DISABILITY MEANS THAT YOU OR YOUR ADULT DEPENDENT ARE PREVENTED, SOLELY BECAUSE OF DISEASE OR ACCIDENTAL BODILY INJURY, FROM ENGAGING IN ANY EMPLOYMENT, AND WITH RESPECT TO A DEPENDENT WHO IS A MINOR, THAT THE DEPENDENT IS PRESENTLY SUFFERING FROM AN ILLNESS OR ACCIDENTAL BODILY INJURY THE EFFECTS OF WHICH ARE LIKELY TO BE OF LONG OR INDEFINITE DURATION AND WHICH WILL PREVENT HIM OR HER FROM ENGAGING IN MOST OF THE NORMAL ACTIVITIES OF A PERSON OF LIKE AGE AND SEX IN GOOD HEALTH.*

PARTICIPANT'S STATEMENT: *(if a participant is mentally or physically unable to do so, this statement may be completed by a member of the family, legal guardian, or any other person having knowledge of such information.)*

1. PARTICIPANT'S INFORMATION:

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ SSN: _____

2. PATIENT'S INFORMATION (IF DIFFERENT FROM #1 ABOVE)

NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PARTICIPANT: _____ SSN: _____

3. NATURE OF PRESENT ILLNESS OR INJURY: _____

4. FIRST DATE OF TOTAL DISABILITY: _____ **5. DATE WORK STOPPED:** _____

6. HAVE YOU ENGAGED IN ANY OCCUPATION OR BUSINESS SINCE THE BEGINNING OF THIS DISABILITY? IF SO, GIVE PARTICULARS: _____

7. PHYSICIAN WHOM YOU CONSULTED DURING PRESENT ILLNESS:

	<u>NAME</u>	<u>ADDRESS</u>	<u>FROM</u>	<u>TO</u>
DR.	_____	_____	_____	_____
DR.	_____	_____	_____	_____

8. HOSPITALS WHERE YOU WERE TREATED DURING PRESENT ILLNESS:

	<u>NAME</u>	<u>ADDRESS</u>	<u>FROM</u>	<u>TO</u>
	_____	_____	_____	_____
	_____	_____	_____	_____

9. WHAT OTHER INSURANCE COVERAGE DO YOU HAVE? (List name, address & effective date of any other plans)

10. ARE YOU NOW COVERED FOR DISABILITY BY THE CITY, STATE, FEDERAL GOVERNMENT OR OTHER EMPLOYER? IF SO, GIVE DATE: _____

DATE

SIGNATURE OF PARTICIPANT