



Disability Certification For an Overage Dependent

This form is for CareFirst BlueCross BlueShield members.

Please **PRINT** all information. When complete, return to the Office of Benefit Services, Department of Human Resources, 8115 Gatehouse Road, Falls Church, VA 22042, or fax to 571-423-5000.

1. Your information

Employee's (or retiree's) name (last, first, middle initial)

Employee's (or retiree's) Social Security 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 23rd birthday, and, because of health reasons, is not capable of self support. I understand that his/her protection under my health insurance coverage will terminate on the last day of the calendar month in which he/she ceases to be disabled.

Employee's (or retiree's) signature

Date (month/date/year)

2. Your Physician Information

Physician name

Street address

City, State, Zip

Telephone number

I certify that I am a physician legally licensed to practice medicine in the Commonwealth/State of

_____. I further certify that in my medical opinion, the above named dependent has

been disabled and has not been capable of self support since _____ . The nature of the

disability is _____ , and in my opinion, he or she will be disabled for

Duration

Physician's signature

Date (month/date/year)

* Providing your Social Security number (SSN) is optional. Failure to provide it may result in processing delays or errors, but will not result in a denial of benefits. The full text of the FCPS SSN privacy notice can be found at www.fcps.k12.va.us/DHR/applicants/disclosures.htm.