



# DISABLED DEPENDENT CERTIFICATION

Post Office Box 9103 \* Van Nuys, California 91409-9103  
In Southern California: 1-800-522-0088  
In Northern California: 1-800-638-3889

## SUBSCRIBER INFORMATION

After completing this section, please forward this form along with the enclosed envelope to your physician for his or her completion.

SUBSCRIBER NAME LAST		FIRST	MI	SUBSCRIBER ID#
ADDRESS		CITY	STATE	ZIP
GROUP NAME			GROUP #	
DEPENDENT NAME		DEPENDENT BIRTH DATE		DEPENDENT MARITAL STATUS
DOES THE DEPENDENT RESIDE IN YOUR HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS HE OR SHE MORE THAN 50% DEPENDENT UPON YOU FOR SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS HE OR SHE LISTED AS DEPENDENT IN YOUR LAST FEDERAL INCOME TAX RETURN? <input type="checkbox"/> YES <input type="checkbox"/> NO
IS DEPENDENT EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, DATE OF HIRE		NUMBER OF HOURS EMPLOYED PER WEEK

DESCRIBE NATURE OF DUTIES

I certify that the above information is correct and authorize the release of medical information requested with respect to this certification.

**X**

SIGNATURE OF SUBSCRIBER

DATE

## TO BE COMPLETED BY ATTENDING PHYSICIAN

An unmarried dependent child who is incapable of self-support due to a continuously disabling illness or injury may be continued as a family member on the parent's Health Net contract. Your medical statement will help us to determine the eligibility of this dependent.

Please return the completed form to Health Net in the enclosed envelope.

PLEASE GIVE US SPECIFICS AS TO THE NATURE OF THE DISABILITY. (ATTACH SUPPORTING DOCUMENTATION.)

TO WHAT EXTENT DOES THE DISABILITY LIMIT NORMAL ACTIVITY? (ATTACH SUPPORTING DOCUMENTATION.)

WHAT IS YOUR PROGNOSIS, INCLUDING YOUR ESTIMATES OF LENGTH OF TIME THIS DISABILITY MAY BE EXPECTED TO CONTINUE? (ATTACH SUPPORTING DOCUMENTAION.)

PHYSICIAN SIGNATURE		NAME OF PHYSICIAN		DATE SIGNED
<b>X</b>				
ADDRESS		CITY	STATE	ZIP