



**BlueAdvantage**  
**Administrators of Arkansas**

An Independent Licensee of the Blue Cross and Blue Shield Association  
P.O. Box 1460  
Little Rock, Arkansas 72203-1460

## EMPLOYEE / PHYSICIAN STATEMENT INCAPACITATED DEPENDENT FORM

| EMPLOYEE'S STATEMENT  |  |  |  |                          |  |      |  |                                |  |       |                          |              |  |          |  |
|---|--|--|--|--------------------------|--|------|--|--------------------------------|--|-------|--------------------------|--------------|--|----------|--|
| EMPLOYEE NAME   |  |  |  | SOCIAL SECURITY NUMBER   |  |      |  | GROUP NAME                     |  |       |                          | GROUP NUMBER |  |          |  |
|   |  |  |  |                          |  |      |  |                                |  |       |                          |              |  |          |  |
| HOME ADDRESS  |  |  |  |                          |  | CITY |  |                                |  | STATE |                          |              |  | ZIP CODE |  |
|   |  |  |  |                          |  |      |  |                                |  |       |                          |              |  |          |  |
| TELEPHONE NUMBERS   |  |  |  |                          |  |      |  |                                |  |       |                          |              |  |          |  |
| HOME  |  |  |  |                          |  |      |  | WORK                           |  |       |                          |              |  |          |  |
|   |  |  |  |                          |  |      |  |                                |  |       |                          |              |  |          |  |
| DEPENDENT'S NAME  |  |  |  | SOCIAL SECURITY NUMBER   |  |      |  | DEPENDENT'S BIRTHDATE          |  |       | RELATIONSHIP TO EMPLOYEE |              |  |          |  |
|   |  |  |  |                          |  |      |  | MO. DAY YR.                    |  |       |                          |              |  |          |  |
|   |  |  |  |                          |  |      |  |                                |  |       |                          |              |  |          |  |
| SEX:<br><input type="checkbox"/> MALE <input type="checkbox"/> FEMALE               |  |  |  | DATE CONDITION COMMENCED |  |      |  | PROBABLE DURATION OF CONDITION |  |       |                          |              |  |          |  |
|   |  |  |  |                          |  |      |  |                                |  |       |                          |              |  |          |  |
| CIRCLE LAST YEAR OF SCHOOL COMPLETED  |  |  |  |                          |  |      |  |                                |  |       |                          |              |  |          |  |
| 1 2 3 4 5 6 7 8 9 10 11 12 COLLEGE 1 2 3 4  |  |  |  |                          |  |      |  |                                |  |       |                          |              |  |          |  |
| IS CHILD A STUDENT NOW?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  | IF YES, WHERE?           |  |      |  |                                |  |       |                          |              |  |          |  |
|   |  |  |  |                          |  |      |  |                                |  |       |                          |              |  |          |  |

I certify the above information is true and correct and the dependent listed above is by reason of mental retardation or physical handicap, residing with me and chiefly dependent upon me for support and maintenance.

EMPLOYEE SIGNATURE \_\_\_\_\_

DATE (Month Day Year) \_\_\_\_\_

### PHYSICIAN'S STATEMENT (To be completed by the physician)

Diagnosis or description of the condition of the above dependent which does not permit employment. (If additional space is needed, please use back of form.)

|  |
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|  |
|  |
|  |
|  |

Date the above named dependent became incapacitated: \_\_\_\_\_  
Month Day Year

Date the above named dependent is expected to be capable of being employed: \_\_\_\_\_  
Month Day Year

I have examined the dependent named above and the degree of his or her disability is of such a nature that he or she would be incapable of sustaining employment.

SIGNATURE OF PHYSICIAN \_\_\_\_\_

DATE \_\_\_\_\_

ADDRESS OF PHYSICIAN \_\_\_\_\_