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 MO.	DAY	YR.	RELATIONSHIP TO EMPLOYEE
	___-___-___				

SEX: ☐ MALE ☐ 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? ☐ YES ☐ 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.)

_____

_____

_____

_____

_____

_____

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