Proof of Incapacity of a Dependent | Policyholder

Policyholder name		Policyholder ID number	
Policyholder SSN - -	**Home phone**	**Work phone**	
Address	**City**	**State**	**ZIP**
Group name		**Group number**	

Dependent name	Dependent SSN - -	Sex ☐ Male ☐ Female	Date of birth	Relationship to policyholder
Primary care physician		**Date disability began**		

Indicate which activities dependent perform or not perform without assistance

☐ **Yes**	☐ **No**	Dress self	☐ **Yes**	☐ **No**	Housework	☐ **Yes**	☐ **No**	Shop for food/necessities
☐ **Yes**	☐ **No**	Bathe	☐ **Yes**	☐ **No**	Manage medications	☐ **Yes**	☐ **No**	Be employed
☐ **Yes**	☐ **No**	Walk	☐ **Yes**	☐ **No**	Manage finances	☐ **Yes**	☐ **No**	Drive
☐ **Yes**	☐ **No**	Cook meals						

Is dependent covered by any other health insurance, including Medicare or Medicaid?
☐ Yes ☐ No

If yes, give policy numbers, effective date, name and address of other insurance company and name in which policy is held:

I certify that the above information is true and correct and that the dependent listed above is incapable of self care/self support, by reason of mental retardation or physical incapacity.

Policyholder signature	Date
Group Administrator Signature (if new member)	**Date**

Please return this signed form to:
ATTN: Corporate Medical Director Division
P.O. Box 2181
Little Rock, AR 72203-9974

Fax: 501-399-3967
Email: CMDIncapacitatedDepReq@arkbluecross.com