

Cambridge Public Employees Dental and Vision Fund
125 CambridgePark Drive, Suite 104
Cambridge, MA 02140

DISABLED DEPENDENT APPLICATION

1. SUBSCRIBER NAME (FIRST, LAST)		
2. SUBSCRIBER ID NUMBER	3. GROUP ID NUMBER	4. GROUP NAME
5. ADDRESS (NUMBER, STREET)		
6. CITY	7. STATE	8. ZIP CODE
9. NAME OF DEPENDENT CHILD	10. CHILD'S DATE OF BIRTH	11. DATE DISABILITY OCCURRED
12. IS CHILD PERMANENTLY RESIDING IN YOUR HOUSEHOLD <input type="checkbox"/> YES <input type="checkbox"/> NO IF "NO" EXPLAIN:		
13. IS CHILD DEPENDENT UPON YOUR SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO	14. IF "YES" WHAT PART OF SUPPORT DO YOU CONTRIBUTE?	
15. IS CHILD LISTED AS A DEPENDENT IN YOUR LAST FEDERAL INCOME TAX STATEMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
16. NAME AND ADDRESS OF PHYSICIAN WHO ATTENDED DEPENDENT CHILD:		
<hr/> <p>I have read the forgoing statement and answers and declare them to be true and complete to the best of my knowledge and belief. To the extent permitted by statute, I here by authorize any physician or person who has attended my above name dependent child or who may hereafter attend or examine such child to disclose knowledge or information thereby acquired by them. A copy of this authorization shall be valid as the original.</p> <hr/>		
_____ SIGNATURE OF SUBSCRIBER		_____ DATE
TO BE COMPLETED BY ATTENDING PHYSICIAN		
1. IS CHILD NOW INCAPABLE OF SELF-SUPPORT BECAUSE OF DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO	2. HAS SUCH DISABILITY EXISTED CONTINUOUSLY SINCE BEFORE CHILD ATTAINED AGE 19? <input type="checkbox"/> YES <input type="checkbox"/> NO	3. PROGNOSIS (ESTIMATE MONTHS OR YEARS)
4. NATURE OF DISABILITY (PLEASE GIVE AS MUCH DETAIL AS PRACTICABLE)		
_____ SIGNATURE OF PHYSICIAN		_____ DATE