Disability Certification For Overage Dependent

I certify that my son/daughter, _____, born on _____, is disabled in accordance to the eligibility rules set forth in my group's contract. I understand that his/her protection under my coverage will terminate as of the last day of the calendar month in which he/she ceases to be so disabled.

_____ _____

Date Parent (Subscriber) Signature

_____

Identification Number

I, _____, certify that I am a physician legally licensed to practice medicine in (the State of) _____. I further certify that, in my medical opinion, _____has been disabled and incapable of self-support since _____. The nature of the disability is_____ _____and, in my opinion, will be for _____ duration. I have attached copies of supporting documentation regarding the disability.

_____ _____

Date Physician's Signature

Please return this form to:

CareFirst BlueCross BlueShield/CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
Attention: Account Implementation Department
Mailstop 31

NOTE: This certification and supporting documentation regarding the disability is subject to approval by qualified personnel of CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc. Formal notification of our decision will be sent to the subscriber.

CUT5799-1S (6/03)