



**KAISER PERMANENTE**  
Insurance Company

P.O. Box 24223  
Oakland, CA 94623-1223

## DISABLED DEPENDENT CERTIFICATION FORM

<i>EMPLOYER NAME</i>		<i>EMPLOYER GROUP NUMBER (IF AVAILABLE)</i>
<i>SUBSCRIBER'S NAME</i>		<i>SUBSCRIBER'S SOCIAL SECURITY NUMBER</i>
<i>DEPENDENT'S NAME</i>		<i>MEDICAL RECORD NUMBER</i>
<i>DATE OF BIRTH</i>	<i>DATE IN WHICH DISABILITY BEGAN</i>	

*NATURE OF DISABILITY*

*IF YOUR DEPENDENT WAS PREVIOUSLY OR IS NOW A KAISER FOUNDATION HEALTH PLAN, INC. MEMBER, PLEASE INDICATE THE LOCATION OF THE KAISER PERMANENTE MEDICAL CENTER WHERE YOUR DEPENDENT USUALLY RECEIVES CARE.*

*WHO IS YOUR DEPENDENT'S PHYSICIAN?*

*TELEPHONE NUMBER WHERE YOU CAN BE REACHED DURING THE DAY*

*NAME OF SCHOOL OR EDUCATION PROGRAM IN WHICH YOUR DEPENDENT IS CURRENTLY ENROLLED*

*DATE ENROLLED*

*SIGNATURE OF SUBSCRIBER* \_\_\_\_\_ *DATE:* \_\_\_\_/\_\_\_\_/\_\_\_\_

*ADDRESS* \_\_\_\_\_  
\_\_\_\_\_