

**KAISER PERMANENTE APPLICATION FOR INCAPACITATED DEPENDENT**

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a Member Services representative before signing this application or card.

**1. Dependent information to be completed by subscriber**

Dependent	Other _____	Male	Female
LAST NAME	FIRST NAME	MI	SUFFIX
_____	_____	_____	_____
DATE OF BIRTH (MM/DD/YYYY)	MEDICAL RECORD # (if enrolled in a Kaiser Permanente plan)	GROUP NUMBER	
_____	_____	_____	
Does dependent live with parent(s)?	Yes	No	
ADDRESS	APARTMENT NUMBER		
_____	_____		
CITY	COUNTY	STATE	ZIP CODE
_____	_____	_____	_____
DAY TIME PHONE (111-222-3333)	EVENING PHONE (111-222-3333)		
3333) _____	_____		
Dependent's marital status:	Single	Married	Divorced      Widowed
EMAIL ADDRESS (OPTIONAL)	_____		
_____	_____		
Is dependent entitled to other insurance?	Yes (If yes, please check applicable boxes below.)		No
	Medicaid	Medicare	Other _____
Is dependent employed?	Yes	No	
EMPLOYER	EMPLOYER ADDRESS		
_____	_____		
APPLICANT SIGNATURE	DATE		
_____	_____		

## 2. Subscriber information

SUBSCRIBER LAST NAME	SUBSCRIBER FIRST NAME	MI	SUFFIX
_____	_____	_____	_____
MEDICAL RECORD # (if enrolled in a Kaiser Permanente plan)	GROUP NUMBER		
_____	_____		
SPOUSE LAST NAME	SPOUSE FIRST NAME	MI	SUFFIX
_____	_____	_____	_____
ADDRESS		APARTMENT NUMBER	
_____		_____	
CITY	COUNTY	STATE	ZIP CODE
_____	_____	_____	_____
DAY TIME PHONE (111-222-3333)		EVENING PHONE (111-222-3333)	
_____		_____	
EMPLOYER	EMPLOYER ADDRESS		
_____	_____		

Does your dependent qualify as your tax deduction?                      Yes                      No

## 3. To be completed by dependent's physician

In your opinion, will dependent ever be capable of self-sustaining employment?                      Yes                      No

Disability:            Temporary            Continuing            Disability likely to improve?            Yes            No

Is dependent presently incapable of self-sustaining employment because of?            Mental incapacity            Physical handicap

Date disability occurred (MM/DD/YYYY): \_\_\_\_\_

Diagnosis of condition causing disabled status and description of limitations:

Physician's comments:

APPLICANT SIGNATURE	DATE (MM/DD/YYYY)
_____	_____
FACILITY	FACILITY ADDRESS
_____	_____

#### 4. To be completed by review committee

Coverage Accepted, how long? \_\_\_\_\_

Rejected, reason:

DATE REVIEWED (MM/DD/YYYY) \_\_\_\_\_

PHYSICIAN'S LAST NAME	PHYSICIAN'S FIRST NAME	MI	SUFFIX
_____	_____	_____	_____

PHYSICIAN'S SIGNATURE  
\_\_\_\_\_

AUTHORIZED SIGNATURE	DATE REVIEWED (MM/DD/YYYY)
_____	_____

DATE MEMBER NOTIFIED (MM/DD/YYYY) _____	TELEPHONE	LETTER
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DATE FORWARDED TO MEMBERSHIP ADMINISTRATION \_\_\_\_\_