



LOS ANGELES FIREMEN'S RELIEF ASSOCIATION

P.O. Box 41903 | Los Angeles | CA 90041
(323) 259-5200 EXT. 223 or 222 firemensrelief.org

DISABLED DEPENDENT CERTIFICATION

MEMBER INFORMATION

ONCE COMPLETING SECTIONS BELOW, FORWARD THE FORM TO YOUR PHYSICIAN FOR FINAL COMPLETION.

FULL NAME (Primary Subscriber, Surviving Spouse or Surviving Domestic Partner)		SOCIAL SECURITY NUMBER		DATE OF BIRTH
ADDRESS		CITY	STATE	ZIP
HOME PHONE	CELL PHONE	EMAIL ADDRESS		

DEPENDENT INFORMATION

DEPENDENTS FULL NAME		DEPENDENTS DATE OF BIRTH	DEPENDENTS MARITAL STATUS
DOES DEPENDENT RESIDE IN YOUR HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS THE DEPENDENT TOTALLY DEPENDENT UPON YOU FOR SUPPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS DEPENDENT EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, DATE OF HIRE?	HOURS WORKED PER WEEK?	
IS DEPENDENT RECEIVING SOCIAL SECURITY DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS DEPENDENT ENROLLED IN MEDICARE or MEDICAID? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please include a copy of Dependent's Medicare ID card.	

I certify the above information is correct and authorize the release of medical information requested with respect to this certification.

Member Signature

Date

TO BE COMPLETED BY ATTENDING PHYSICIAN

A child reaching 26 who is TOTALLY dependent on the Member because of a physical or mental TOTAL disability and incapable of ANY type or level of employment may, in certain circumstances, be eligible for continued coverage. Your completed statement below will help determine such eligibility.
Please include in your statement a description of the extent to which the patient is cooperating in the care he/she is receiving.

PLEASE RETURN THE COMPLETED FORM TO LAFRA MEMBER SERVICES DEPARTMENT - ADDRESS INFORMATION (TOP LEFT)

Please give us specifics as to the nature of the disability (Attach supporting documentation)

To what extent does the disability limit normal activity? (Attach supporting documentation)

Describe how the patient is cooperating in the care you are providing:

What is your prognosis including your estimates of length of time this disability may be expected to continue? (Attach supporting documentation)

PHYSICIAN'S SIGNATURE		PHYSICIAN'S NAME		DATE OF SIGNATURE
ADDRESS		CITY	STATE	ZIP
PHONE	EMAIL ADDRESS			