BlueAdvantage Administrators of Arkansas
An Independent Licensee of the Blue Cross and Blue Shield Association
P.O. Box 1460
Little Rock, Arkansas 72203-1460

EMPLOYEE / PHYSICIAN STATEMENT INCAPACITATED DEPENDENT FORM

EMPLOYEE'S STATEMENT

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	GROUP NAME	GROUP NUMBER
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HOME ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBERS

HOME	WORK

DEPENDENT'S NAME	SOCIAL SECURITY NUMBER	DEPENDENT'S BIRTHDATE			RELATIONSHIP TO EMPLOYEE
		MO.	DAY	YR.	
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SEX: ☐ MALE ☐ FEMALE	DATE CONDITION COMMENCED	PROBABLE DURATION OF CONDITION

CIRCLE LAST YEAR OF SCHOOL COMPLETED

1 2 3 4 5 6 7 8 9 10 11 12 COLLEGE 1 2 3 4

IS CHILD A STUDENT NOW? ☐ YES ☐ NO	IF YES, WHERE?

I certify the above information is true and correct and the dependent listed above is by reason of mental retardation or physical handicap, residing with me and chiefly dependent upon me for support and maintenance.

EMPLOYEE SIGNATURE ____________________ DATE *(Month Day Year)* ____________________

PHYSICIAN'S STATEMENT (To be completed by the physician)

Diagnosis or description of the condition of the above dependent which does not permit employment. (If additional space is needed, please use back of form.)

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Date the above named dependent became incapacitated: ____________________
Month Day Year

Date the above named dependent is expected to be capable of being employed: ____________________
Month Day Year

I have examined the dependent named above and the degree of his or her disability is of such a nature that he or she would be incapable of sustaining employment.

SIGNATURE OF PHYSICIAN ____________________ DATE ____________________

ADDRESS OF PHYSICIAN ____________________