Dependent Disability Evidence of Insurability Form

Policyholder Information

Name of Employee/Member

Policy Number

Employer/Group Name

Employee ID (if applicable)

Dependent Information

Full Name

Relationship to Employee

Date of Birth

Gender

Select

Disability Details

Nature of Disability

Date Disability Commenced

Describe the disability and degree to which it affects daily activities

Describe the extent to which the dependent relies on the employee/member for support

Physician Information

Physician's Name

Address

Phone Number

_____

Signature of Employee/Member

_____

Date