blue california

Subscriber statement of disability:

This information to be completed as it pertains to the totally disabled family member

To avoid any unnecessary delays, please answer every question completely.

Full name of subscriber	Name of disabled family member	Date of birth
Physical address (Number, street, city, state, and ZIP code)	Mailing address (Number, street, city, state, and ZIP code) if different than physical address	Blue Shield subscriber no.

1. What was the Disabled Person's occupation (job title, homemaker, student, etc.) at the time they became disabled?		
2. What were his/her usual daily duties?		
3. What occupations did he/she hold during the past five years?		
4. When did the injury occur or illness begin?	_____, 20____	
5. What was the nature of the injury or illness?		
6. A. Had he/she been in good health until now? B. If no, give particulars.	A. ☐ Yes ☐ No B.	
7. List all conditions causing the total disability including symptoms (conditions not diagnoses).		
8. Provide the requested information for physicians consulted for the answer to number 7.	**First physician consulted:** Name _____ Physical address _____ City and ZIP code _____ Mailing address _____ City and ZIP code _____ Date first seen _____, 20____ Date last seen _____, 20____	**Present attending physician:** Name _____ Physical address _____ City and ZIP code _____ Mailing address _____ City and ZIP code _____ Date first seen _____, 20____ Are you still under his/her care? ☐ Yes ☐ No
9. Please provide name(s) and address(es) of any other physicians seen for conditions described in Number 7 (use additional sheet if necessary).		
10. A. Was the Disabled Person confined to hospital, house, or bed? B. If yes, give dates.	☐ HOSP. From _____, 20____ to _____, 20____ ☐ HOUSE From _____, 20____ to _____, 20____ ☐ BED From _____, 20____ to _____, 20____	
11. A. By whom was the Disabled Person employed at the time of his/her injury or illness? B. If student, please give name and address of school.	A. B.	

12. A. Since the date stated in answer to Question 4, has the Disabled Person been able to perform any kind of work?	A. ☐ Yes ☐ No
B. If yes, state nature of work performed and the date any kind of work was last performed.	B.
C. If no, was the Disabled Person too ill to perform normal activities?	C. ☐ Yes ☐ No
13. A. Does the Disabled Person at the present time perform any kind of work?	A. ☐ Yes ☐ No
B. If yes, state nature of work.	B.
C. If student, was he/she able to return to school?	C. ☐ Yes ☐ No
14. A. Has the Disabled Person tried to find employment in other than his/her regular occupation?	A. ☐ Yes ☐ No
B. If yes, state details.	B.
15. A. Does the Disabled Person have any other health coverage?	A. ☐ Yes ☐ No
B. If yes, give the name of carrier, policy ID #, and policyholder.	B.
16. A. Does the Disabled Person have Medicare?	A. ☐ Yes ☐ No
B. If yes, state details.	B. Part A effective date _____, 20____ Part B effective date _____, 20____
17. A. Is the Disabled Person on disability?	A. ☐ Yes ☐ No
B. Has the Disabled Person filed for Worker's Compensation Benefits?	B. ☐ Yes ☐ No
C. Has the Disabled Person applied for COBRA coverage?	C. ☐ Yes ☐ No

Subscriber's signature

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I certify that the foregoing information is accurate and complete, and authorize the release of any medical information necessary to process my application for extension of benefits.

X _____ _____

Subscriber signature Date

X _____ _____

Member signature if over 18 Daytime phone