USAble Mutual Insurance Company
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PROOF OF INCAPACITY OF A DEPENDENT
SUBSCRIBER'S FORM

Subscriber Name ______________________________ Subscriber ID# ______________

Subscriber SSN# ______________________________ Home Phone ______________

Address ______________________________ Work Phone ______________

Group Name ______________________ Group Number ______________________

Dependent Name ______________________ Dependent SSN ______________________

Sex: • Male • Female Date of Birth __________ Relationship to Subscriber ______________

Primary Care Physician______________________________ Date Disability Began __________

Indicate which activities the dependent is able to perform without assistance:

Yes	No	
		Dress Self
		Bathe
		Walk
		Cook Meals
		Housework

Yes	No	
		Manage Finances
		Drive
		Be Employed
		Manage Medications
		Shop for Food/Necessities

Is dependent covered by any other health insurance including Medicare or Medicaid? • Yes • No

If yes, give policy numbers, effective date, name and address of other insurance company and name in which policy is held: ______________________________

I certify that the above information is true and correct and that the dependent listed above is, by reason or mental retardation or physical incapacity.

______________________________ ______________
Subscriber Signature Date

______________________________ ______________
Group Administrator Signature (if new member) Date