CHICAGO BENEFITS OFFICE
2 N. LASALLE STREET, ROOM 1240
CHICAGO, ILLINOIS 60602
1-877-299-5111

APPLICATION

Employee Request for Dependent Incapacity Coverage

This form is to be completed by the City of Chicago employee

Employee Name: _____ Date: _____

Employee Address: _____ Zip Code: _____

Employee Social Security Number: _____

Telephone No.: _____

Dependent Name: _____

Dependent Social Security Number: _____

Dependent Birth Date: _____

Is your dependent currently physically and/or mentally disabled? YES_____ NO_____

Do you provide more than 50% of financial support for your dependent? YES_____ NO_____

Is your dependent currently covered under Medicare? YES _____NO _____
(If yes, attach a copy of Medicare card)

Is your dependent currently covered under any other hospital / medical plan? YES_____NO_____

If yes, provide the name of the insurance company: _____

Group, certificate, or agreement number: _____

I hereby request that the above dependent be allowed to continue/reinstate coverage under my City of Chicago Medical Plan as an incapacitated dependent.

Signature: _____ Date: _____
(Employee's Signature)

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Physician Statement of Dependent Incapacity Form

Original Document Required - Do Not Send Copies Via Fax

This form has two parts; both parts must be completed. Part I must be completed by the dependent or the guardian of the dependent; Part II must be completed by the dependent's Physician.

Employee Name:_____

Dependent Name:_____

Social Security No:_____

Part I
To be completed by dependent or dependent's guardian

I, _____, hereby authorize _____
to release the information requested on this form to the City of Chicago, Chicago Benefits Office and its vendors Blue Cross / Blue Shield of Illinois and Telligen for the purpose of verifying my medical status.

Signature: _____ Date: _____

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Part II

To be completed by the physician

This information will be requested on a yearly basis.

1. Is the dependent incapable of self-support because of disability? YES_____ NO_____
2. Disability has existed continuously since _____
3. Diagnosis and extent of disability (please describe in detail): _____
   _____
   _____
   _____
   _____
4. Prognosis: _____
   _____
5. Does the dependent live at home with the employee? YES_____ NO_____
6. Is the dependent institutionalized? YES_____ NO_____
7. If yes, please indicate name / address of the institution / facility:
   _____
   _____

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Physician signature: _____Date: _____
Name of Physician (Please Print): _____
Address: _____ City/State: _____Zip:_____
Physician I.D. Number: _____ Phone Number: _____