AFFIDAVIT OF QUALIFYING INCAPACITATED DEPENDENT

EMPLOYEE STATEMENT: Please answer all questions as missing information may cause delays.

Last Name:		First Name:		M.I.
Date of Birth:		Social Security No.:		Sex: M F
Current Address (Street):				
City:	State:	Zip:	Phone:	

DEPENDENT INFORMATION:

Last Name:		First Name:		M.I.
Date of Birth:		Social Security No.:		Sex: M F
Current Address (Street):				
City:	State:	Zip:	Phone:	
Name of Dependent's Current Employer:				
Employer's Address (Street):				
City:	State:	Zip:	Phone:	

If not employed, provide the date of last employment period:	Date:
Estimated income of dependent from all sources:	$ Monthly
Percentage of support supplied by employee:	%
Is dependent permanently residing in employee's household?	Yes No
Is this individual listed as a dependent on your last Federal Personal Income Tax Return?	Yes No
If not, explain:	

I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Employee Signature ______________________ Date ______________

PRIMARY PHYSICIAN STATEMENT: (Any fee for the completion of this statement is to be paid by the employee.)

Please answer all questions as missing information may cause delays.

Patient Information:

Last Name:	First Name:	M.I.	Date of Birth:
Has the dependent been declared as disabled by the Social Security Administration?			Yes No
Date dependent became incapable of self-sustainable employment:			Date:

Diagnosis of condition causing incapacity. Give as much detail as possible. Please give date and report of surgery, X-rays, electrocardiograms, or other special tests. Use a separate sheet of paper if necessary.

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PRIMARY PHYSICIAN STATEMENT CONTINUED:

Do you know if the patient is employed?	Yes	No
If yes, do you know what the patient's job is?	Yes	No
Do you know what duties the patient's job requires? Please describe, if known.	Yes	No
Has the patient been able to do full or part-time work of any kind?	Yes	No
Do you anticipate the patient will become capable of self-support?	Yes	No

The patient is presently (Check One): Ambulatory Bed confined House confined Hospital confined

PRIMARY PHYSICIAN INFORMATION:

Last Name:	First Name:	M.I.
Current Address (Street):		

City:	State:	Zip:	Phone:

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Primary Physician Signature Date

EMPLOYER'S STATEMENT:

Employee's Information:

Last Name:	First Name:	M.I.
Date Dependent's coverage was originally effective if prior to TPSC services:		
If previously cancelled, give date:		

Employer:	Group #:	Division:

Employer Signature Title Date

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