DELTA DENTAL
Delta Dental of Missouri

APPLICATION FOR DISABLED OR HANDICAPPED DEPENDENT CHILDREN
(To be Completed by Subscriber)

Subscriber Name: _____

Social Security Number: _____ Group Number: _____

Address: _____

Street City State Zip

Name of disabled or handicapped dependent: _____

Age: _____ Birth date: _____ Date of disability: _____

I certify the above named son or daughter has been incapable of self support prior to and since his or her 19th birthday and that I am providing full support for this dependent.

_____ _____

Signature of Subscriber Date

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PLEASE HAVE YOUR PHYSICIAN COMPLETE THE FOLLOWING BEFORE SUBMISSION TO DELTA DENTAL OF MISSOURI.

Name of Patient: _____

Description of Disability or Handicap: _____

_____

Date first treated: _____ Date last treated: _____

Based on your medical records, is the patient's disability or handicap of such extent as to make him or her incapable of self support? Yes_____ No_____

Is disability or handicap permanent? Yes_____ No_____

_____ _____

Signature of Physician Date