Los Angeles Firemen's Relief Association
P. O. Box 41903
Los Angeles, CA 90041
Maria Rodriguez (323) 259-5222
Ana Salazar (323) 259-5223
www.lafra.org

Disabled Dependent Certification

Member Information:

(After completing this section, please forward this form along with the enclosed envelope to your physician for his or her completion.)

Member's Full Name:	Social Security Number:	Birthdate:	
Address:	City:	State:	Zip:
Telephone Number:	Email Address:		

Dependent Information:

Dependent's Name:	Dependent's Birthdate:	Dependent's Marital Status:
Does Dependent reside in your home: ☐ Yes or ☐ No	Is Dependent totally dependent upon you for support? ☐ Yes or ☐ No	
Is dependent employed: ☐ Yes or ☐ No	If yes, date of hire:	Number of hours worked per week:
Is dependent receiving Social Security Disability? ☐ Yes or ☐ No	Is dependent enrolled in Medicare or Medicaid? ☐ Yes or ☐ No If Yes, please include a copy of Dependent's Medicare ID card.	

I certify the above information is correct and authorize the release of medical information requested with respect to this certification.

Member's Signature Date

TO BE COMPLETED BY ATTENDING PHYSICIAN

A child reaching 26 who is TOTALLY dependent on the Member because of a physical or mental TOTAL disability and incapable of ANY type or level of employment may, in certain circumstances, be eligible for continued coverage. Your completed statement below will help determine such eligibility. Please include in your statement a description of the extent to which the patient is cooperating in the care he/she is receiving.

PLEASE RETURN THE COMPLETED FORM TO THE MEMBERSHIP DEPARTMENT IN THE ENCLOSED ENVELOPE.

Please give us specifics as to the nature of the disability (Attach supporting documentation)
To what extent does the disability limit normal activity? (Attach supporting documentation)
Describe how the patient is cooperating in the care you are providing:
What is your prognosis including your estimates of length of time this disability may be expected to continue? (attach supporting documentation)

Physician's Signature:	Name of Physician		Date Signed
Address	City	State	Zip