LOS ANGELES FIREMEN'S
**RELIEF ASSOCIATION**
P.O. Box 41903 | Los Angeles | CA 90041
(323) 259-5200 EXT. 223 or 222 firemensrelief.org

# DISABLED DEPENDENT CERTIFICATION

## MEMBER INFORMATION

**ONCE COMPLETING SECTIONS BELOW, FORWARD THE FORM TO YOUR PHYSICIAN FOR FINAL COMPLETION.**

| FULL NAME | | LAST 4 DIGITS OF SSN | | DATE OF BIRTH |
|---|---|---|---|---|
| ADDRESS | | CITY | STATE | ZIP |
| HOME PHONE | CELL PHONE | EMAIL ADDRESS | | |

## DEPENDENT INFORMATION

| DEPENDENTS FULL NAME | DEPENDENTS DATE OF BIRTH | DEPENDENTS MARITAL STATUS |
|---|---|---|
| DOES DEPENDENT RESIDE IN YOUR HOME? ☐ YES ☐ NO | IS THE DEPENDENT TOTALLY DEPENDENT UPON YOU FOR SUPPORT? ☐ YES ☐ NO | |
| IS DEPENDENT EMPLOYED? ☐ YES ☐ NO | IF YES, DATE OF HIRE? | HOURS WORKED PER WEEK? |
| IS DEPENDENT RECEIVING SOCIAL SECURITY DISABILITY? ☐ YES ☐ NO | IS DEPENDENT ENROLLED IN MEDICARE or MEDICAID? ☐ YES ☐ NO<br>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 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 *LAFRA MEMBER SERVICES DEPARTMENT* - ADDRESS INFORMATION (TOP LEFT)**

| |
|---|
| *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 | PHYSICIAN'S NAME | | DATE OF SIGNATURE |
|---|---|---|---|
| ADDRESS | CITY | STATE | ZIP |
| PHONE | EMAIL ADDRESS | | |