Print Form

DELTA DENTAL®

PHONE: 617-354-1110
FAX: 617-354-3315
EMAIL: info@cdvfund.org

Cambridge Public Employees
Dental and Vision Fund
125 CambridgePark Drive, Suite 104
Cambridge, MA 02140

Disabled Dependent Application

1. SUBSCRIBER NAME
FIRST LAST

2. SUBSCRIBER ID NUMBER	3. GROUP ID NUMBER	4. GROUP NAME

5. ADDRESS (Number, Street, City, State and Zip Code)

6. NAME OF DEPENDENT CHILD	7. CHILD'S DATE OF BIRTH	8. DATE CHILD'S DISABILITY OCCURRED
	Month / Date / Year	

9. IS CHILD PERMANENTLY RESIDING IN YOUR HOUSEHOLD ☐ Yes ☐ No IF "NO," EXPLAIN:

10. IS CHILD DEPENDENT UPON YOU FOR SUPPORT?	11. IF "YES," WHAT PART OF SUPPORT DO YOU CONTRIBUTE?	12. IS CHILD LISTED AS A DEPENDENT IN YOUR LAST FEDERAL INCOME TAX STATEMENT?
☐ YES ☐ NO		☐ YES ☐ NO

13. NAME AND ADDRESS OF PHYSICIAN WHO ATTENDED DEPENDENT CHILD.

I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge and belief. To the extent permitted by statute, I here by authorize any physician or other person who has attended my above name dependent child o rwho may hereafter attend or examine such child to disclose any knowledge or information thereby acquired by him. Aphotostat of this authorization shall be valid as the original.

SIGNATURE OF SUBSCRIBER DATE

Return Form Directly To: Cambridge Public Employees Dental & Vision Fund
125 CambridgePark Drive, Suite 104
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TO BE COMPLETED BY ATTENDING PHYSICIAN

1. IS CHILD NOW INCAPABLE OF SELF-SUPPORT BECAUSE OF A DISABILITY?	2. HAS SUCH DISABILITY EXISTED CONTINUOSLY SINCE BEFORE CHILD ATTAINED AGE 19?	3.PROGNOSIS (Estimate months or years)
☐ YES ☐ NO	☐ YES ☐ NO	

4. NATURE OF DISABILITY (Please give as much detail as practicable)

SIGNATURE OF PHYSICIAN DATE