DENVER HEALTH MEDICAL PLAN INC.™

STATEMENT OF DEPENDENT ELIGIBILITY BEYOND LIMITING AGE IN PLAN DUE TO DEVELOPMENTALLY DISABLED OR MENTAL OR PHYSICAL HANDICAP

SUBSCRIBER STATEMENT

Answer all questions below. Omitted information will cause delays.

Name (First, Middle, Last) Social Security #

Present Street Address City, State, Zip Code

Phone # Date of Birth

Gender: O Female O Male

Marital Status: O Single O Married O Widowed O Divorced

DEPENDENT INFORMATION

Name (First, Middle, Last) Social Security #

Present Street Address City, State, Zip Code

Relationship to Subscriber Date of Birth

Name and address of dependent's current employer

If not now employed, give date last employed Estimated monthly income of dependent from all sources

% of support of dependent supplied by subscriber

Gender: O Female O Male

Marital Status: O Single O Married O Widowed O Divorced

Is dependent permanently residing in subscriber's household?: O Yes O No (If no, explain below.)

Is dependent listed as a dependent on your last Federal Personal Income Tax Return?: O Yes O No (If no, explain below.)

Explanations

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.

Subscriber Signature Date

PHYSICIAN/SURGEON/CRNP STATEMENT

Any fee for the completion of this form is to be paid by the subscriber. Answer all questions below. Omitted information will cause delays.

Patient's Name (First, Middle, Last) Patient's Date of Birth

Is this dependent presently incapable of self-sustaining employment by reason of:

Developmentally Disabled: O Yes O No Physical Handicap: O Yes O No

Mental Handicap: O Yes O No Other (Explain): O Yes O No

Explanation

Date dependent became incapable of self-sustaining employment

Diagnosis of condition causing incapacity. If developmental disability is present, give degree of disability. 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.

Does the patient have a job?: O Yes O No

Do you know what the patient's job is?: O Yes O No

Do you know what duties the patient's job requires?: O Yes O No

Has the patient been able to do full or part-time work of any kind?: O Yes, from date___________ O No

Will the patient be capable of self support?: O Yes O No

The patient is presently (check one):

O Ambulatory O Bed-confined O House-confined O Hospital-confined

Physician/Surgeon/CRNP Name (Print) Address Phone #

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Physician/Surgeon/CRNP Signature Date

FOR DHMP USE ONLY

Dependent eligibility will continue to Month / Day / Year

Dependent eligibility declined. Give reason.

Product Line Manager Signature Date