



MID-ATLANTIC, INC

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Calverton, MD 20705
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EMPLOYEE PLEASE GIVE YOUR
COMPLETED FORM TO YOUR BENEFITS
ADMINISTRATOR

ADMINISTRATOR PLEASE MAIL
COMPLETED ENROLLMENT FORMS TO:

DentaQuest
PO BOX 9708
BOSTON, MA 02114-9708

Disabled Dependent Form

1. SUBSCRIBER NAME		
FIRST	LAST	
2. SUBSCRIBER ID NUMBER	3. GROUP NUMBER	4. GROUP NAME
5. ADDRESS (Number, Street, City, State and Zip Code)		
6. NAME OF DEPENDENT CHILD	7. CHILD'S DATE OF BIRTH Month Date Year	8. DATE CHILD'S DISABILITY OCCURRED
9. IS CHILD PERMANENTLY RESIDING IN YOUR HOUSEHOLD? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "NO," EXPLAIN:		
10. IS CHILD DEPENDENT UPON YOU FOR SUPPORT? <input type="checkbox"/> Yes <input type="checkbox"/> No	11. IF "YES," WHAT PART OF SUPPORT DO YOU CONTRIBUTE?	12. IS CHILD LISTED AS A DEPENDENT IN YOUR LAST FEDERAL INCOME TAX STATEMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No
13. NAME AND ADDRESS OF PHYSICIAN WHO ATTENDED DEPENDENT CHILD.		
<p>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 hereby authorize any physician or other person who has attended my above named dependent child or who may hereafter attend or examine such child to disclose any knowledge or information thereby acquired by him. A photostat of this authorization shall be valid as the original.</p>		
<hr style="width: 50%; margin: 0 auto;"/> SIGNATURE OF SUBSCRIBER		<hr style="width: 50%; margin: 0 auto;"/> DATE
Return Form Directly To: DentaQuest P.O. Box 9708 Boston, MA 02114-9708		
TO BE COMPLETED BY ATTENDING PHYSICIAN		
1. IS CHILD NOW INCAPABLE OF SELF-SUPPORT BECAUSE OF A DISABILITY? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. HAS SUCH DISABILITY EXISTED CONTINUOUSLY SINCE BEFORE CHILD ATTAINED AGE 19? <input type="checkbox"/> Yes <input type="checkbox"/> No	3. PROGNOSIS (Estimate months or years)
4. NATURE OF DISABILITY (Please give as much detail as practicable)		
<hr style="width: 50%; margin: 0 auto;"/> SIGNATURE OF PHYSICIAN		<hr style="width: 50%; margin: 0 auto;"/> DATE