



VIRGINIA, 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>14. AUTHORIZATION. I am requesting coverage for the above named dependent, and to the extent permitted by statute, I hereby authorize any physician or other person who has attended, or may hereafter attend or examine, my above named dependent child to disclose to DentaQuest Virginia, Inc., its agents and employees any information or knowledge thereby acquired by such health care professionals. This authorization is valid for 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or request to change benefits. The subscriber or the subscriber's authorized representative is entitled to receive a copy of the authorization form. A Photostat of this authorization shall be valid as the original.</p> <p>15. CERTIFICATION. I have carefully read this Form and agree to its terms. The answers recorded on this Form are, to the best of my knowledge and belief, full, complete and true as of this date.</p>		
<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> SIGNATURE OF SUBSCRIBER		<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> 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="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> SIGNATURE OF PHYSICIAN		<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> DATE