ncas®
The Team Approach to Benefit Administration

Disability Certification

For an Over-age Dependent

Employer:	Subgroup:
Employee:	Identification Number:

Dependent Name:	Date of Birth:

I hereby certify that my son/daughter named above, is unmarried, became disabled prior to his/her nineteenth (19th) birthday or (twenty-third (23rd) birthday if a full-time student), and, because of health reasons, is incapable of self-support. I understand that his/her protection under my coverage will terminate according to the Summary Plan Description for my group.

_____ _____

Employee's Signature Date

Physician Name:	
Street Address:	
City, State, Zip:	Telephone Number:

I certify that I am a physician legally licensed to practice medicine in the State of _____.

I further certify that, in my medical opinion, the above-named dependent has been disabled and is incapable of self-support since _____. The nature of the disability is _____

_____

and, in my opinion, will be for _____ duration.

_____ _____

Physician's Signature Date