USAble Mutual Insurance Company
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PROOF OF INCAPACITY OF A DEPENDENT
PHYSICIAN'S FORM

Subscriber Name _____ Subscriber # _____

Address _____

Dependent Name _____

The Insurer covers dependent children that have reached the maximum dependent age that are physically or mentally incapacitated. In order to make a determination, the following information must be completed. Please attach any supporting documentation.

Current Age _____ Height _____ Weight _____ Mental Incapacity _____ If Yes, Add IQ Score _____

Physical Incapacity _____ Age at onset of condition/disability _____

Describe incapacity or reason incapable of self care/self support

_____

_____

Acute Medical Conditions (describe)

_____

_____

Chronic Medical Conditions (describe)

_____

_____

Future health concerns or considerations

_____

_____

Medications, dosage, reason for medications

_____

_____

Other important facts

_____

A copy of any pertinent medical information may be attached.

I have examined the dependent named above, and the degree of his/her disability or incapacity is of such a nature that he/she is incapable of self care/self support.

Physician Name	Specialty
Physician Signature	Date