DELTA DENTAL®

Application for Extended Dependent Dental Plan Eligibility

Part I - To Be Completed By Employee or Primary Plan Participant and/or Authorized Representative

Name of Employee or Primary Plan Participant _____ Social Security No. or Dental Plan ID # _____

Dependent's Name: _____ Dependent's DOB _____

As an Authorized Representative (parent, guardian, etc.), I authorize release of all medical information on the above named dependent, including medical history, diagnosis, prognosis and treatment of any physical or mental condition.

Name (please print) _____ Relationship to Dep _____

_____ _____

Signature Date signed

Part II - To Be Completed By Dependent's Attending Physician

Primary Diagnosis: _____

Other related diagnosis: _____

Date patient first consulted you for these conditions: _____

Date of most recent visit: _____

Describe the patient's physical, mental and cognitive limitations and work/activity limitations:

Is the patient totally disabled? _____ Yes _____ No

Please provide the date the patient became totally disabled: _____

When do you expect a fundamental or marked change in patient's condition?

Check One: _____ Never _____ Condition expected to regress _____ Condition expected to improve

If applicable, anticipated date of recovery _____ or, unable to determine; follow up in _____ months.

Remarks: _____

Physician's Signature: _____ **Date:** _____

Physician's Name (please print): _____

Physician's Address: _____ **Phone:** _____

Return this form to:

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