Blue Shield of California
An Independent Member of the Blue Shield Association

Blue Shield of California Life & Health Insurance Company
An Independent Licensee of the Blue Shield Association

SUBSCRIBER STATEMENT OF DISABILITY:

THIS INFORMATION TO BE COMPLETED AS IT PERTAINS TO THE TOTALLY DISABLED FAMILY MEMBER

To avoid any unnecessary delays, please answer every question completely.

FULL NAME OF SUBSCRIBER	NAME OF DISABLED FAMILY MEMBER	DATE OF BIRTH
PHYSICAL ADDRESS (Number, Street, City, State and Zip Code)	MAILING ADDRESS (Number, Street, City, State and Zip Code) IF DIFFERENT THAN PHYSICAL ADDRESS	BLUE SHIELD SUBSCRIBER NO.

1. What was the Disabled Person's occupation (job title, housewife, student, etc.) at the time they became disabled?	
2. What were his/her usual daily duties?	
3. What occupations did he/she hold during the past five years?	
4. When did the injury occur or illness begin?	________________, 20 ______ .
5. What was the nature of the injury or illness?	
6. A. Had he/she been in good health until now? B. If no, give particulars.	A. ❑ YES ❑ NO B.
7. List all conditions causing the total disability including symptoms. (Conditions not Diagnoses).	
8. Provide the requested information for physicians consulted for the answer to number 7.	First Physician Consulted: Name ____________ Physical Address ____________ City & Zip Code ____________ Mailing Address ____________ City & Zip Code ____________ Date First Seen ________, 20 ______ . Date Last Seen ________, 20 ______ . Present Attending Physician: Name ____________ Physical Address ____________ City & Zip Code ____________ Mailing Address ____________ City & Zip Code ____________ Date First Seen ________, 20 ______ . Are you still under his/her care? ❑ YES ❑ NO
9. Please provide name(s) and address(es) of any other physicians seen for conditions described in Number 7. (Use additional sheet if necessary.)	

CONTINUED ON REVERSE SIDE

Customer Advocacy/Extension of Benefits
4203 Town Center Blvd., El Dorado Hills, CA 95762-9806
www.mylifepath.com

C-12198 (1/04)

Question	Answer
10. A. Was the Disabled Person confined to hospital, house, or bed? B. If yes, give dates.	❑ HOSP. From ______, 20 ___ to ______, 20 ___ ❑ HOUSE From ______, 20 ___ to ______, 20 ___ ❑ BED From ______, 20 ___ to ______, 20 ___
11. A. By whom was the Disabled Person employed at the time of his/her injury or illness? B. If student, please give name and address of school.	A. B.
12. A. Since the date stated in answer to Question 4, has the Disabled Person been able to perform any kind of work? B. If yes, state nature of work performed and the date any kind of work was last performed. C. If no, was the Disabled Person too ill to perform normal activities?	A. ❑ YES ❑ NO B. C. ❑ YES ❑ NO
13. A. Does the Disabled Person at the present time perform any kind of work? B. If yes, state nature of work. C. If student, was he/she able to return to school.	A. ❑ YES ❑ NO B. C. ❑ YES ❑ NO
14. A. Has the Disabled Person tried to find employment in other than his/her regular occupation? B. If yes, state details.	A. ❑ YES ❑ NO B.
15. A. Does the Disabled Person have any other health coverage? B. If yes, give the name of Carrier, Policy ID#, and name of Policyholder.	A. ❑ YES ❑ NO B.
16. A. Does the Disabled Person have Medicare? B. If yes, state details.	A. ❑ YES ❑ NO B. Part A. - Effective Date ______ 20 ___ Part B. - Effective Date ______ 20 ___
17. A. Is the Disabled Person on disability? B. Has the Disabled Person filed for Worker's Compensation Benefits? C. Has the Disabled Person applied for COBRA coverage?	A. ❑ YES ❑ NO B. ❑ YES ❑ NO C. ❑ YES ❑ NO

SUBSCRIBER'S SIGNATURE

I certify that the foregoing information is accurate and complete, and authorize the release of any medical information necessary to process my application for extension of benefits.

X ______________________ SUBSCRIBER SIGNATURE ______________ DATE

X ______________________ MEMBER SIGNATURE IF OVER 18 (____) ______________ AREA CODE DAYTIME PHONE