DELTA DENTAL®

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TO BE COMPLETED BY THE POLICYHOLDER

Policyholder Name:

Address:

Dependent's Name:

Dependent's Date of Birth:

Dependent's Relationship to Policyholder:

Policyholder is responsible for at least 50% of this Dependent's support? ☐ YES ☐ NO

TO BE COMPLETED BY ATTENDING PHYSICIAN

Can this Dependent support himself/herself? ☐ YES ☐ NO

If no, is this because of a Disability? ☐ YES ☐ NO

Was the Dependent Disabled prior to their 19th birthday? ☐ YES ☐ NO

Date Disability occurred:

Prognosis (estimated length of Disability):

Describe the nature of this Dependent's Disability:

Signature of Physician:	Date:

Sincerely,

Delta Dental

Delta Dental
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