

**APPLICATION FOR DISABLED OR HANDICAPPED DEPENDENT CHILDREN
(To be Completed by Subscriber)**

Subscriber Name: _____

Social Security Number: _____ Group Number: _____

Address: _____

Street

City

State

Zip

Name of disabled or handicapped dependent: _____

Age: _____ Birth date: _____ Date of disability: _____

I certify the above named son or daughter has been incapable of self support prior to and since his or her 19th birthday and that I am providing full support for this dependent.

Signature of Subscriber

Date

**PLEASE HAVE YOUR PHYSICIAN COMPLETE THE FOLLOWING
BEFORE SUBMISSION TO DELTA DENTAL OF MISSOURI.**

Name of Patient: _____

Description of Disability or Handicap: _____

Date first treated: _____

Date last treated: _____

Based on your medical records, is the patient's disability of handicap of such extent as to make him or her incapable of self support? Yes _____ No _____

Is disability or handicap permanent? Yes _____ No _____

Signature of Physician

Date