Disability Questionnaire

To Be Completed by Subscriber (please print clearly)

Subscriber Name			Member ID #	
Street Address	Apt #	City	State	Zip Code

Are you or any of your family members disabled? Yes No

If "Yes," please complete the sections below.

Disabled Member's Name	Birthdate Month Day Year
Is the disabled Member covered by any health insurance other than Oxford (including Medicare or Medicaid)? If "Yes": Name of Carrier Effective Date of Coverage Policy Number Please enclose a copy of the insurance card.	

I attest to the best of my knowledge that the information I provided is correct.
That (if applicable) the dependent named above (if such dependent is a child age 19 or older) is unmarried and is chiefly dependent upon me for economic support and maintenance.

Subscriber Signature Date

To Be Completed by Physician (please print clearly)

Disability diagnosis		Please indicate the status of the disability _____ Temporary _____ Permanent	
Description of disability			
Date disability commenced	Age at which disability arose		
Is the individual listed above capable of self-sustaining employment or attending school on a full-time basis (if 19-25 years of age)?		At this time? YES NO	In the future? YES NO
If 'No" was circled for any response above, please provide a brief explanation.			

Physician Signature Date

Print Name: ____

Address: ____

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