



Please print in blue or black ink.

Group Number 085000 www.trs.state.tx.us/trs-activecare Toll-Free Customer Service 1.866.355.5999

District/Employer Name

**SECTION 1 — TO BE COMPLETED BY THE EMPLOYEE** For disabled children, age 25 and over

Employee's Last Name				First Name				Middle Initial	
Employee's Social Security Number				Work Phone			Home Phone		
Employee's Mailing Address				City			State	ZIP Code	
Dependent Child's Last Name				First Name				Middle Initial	
Dependent Child's Social Security Number				Dependent Child's Date of Birth			Dependent Child's Marital Status		
				MM	DD	YYYY			
Dependent Child's Place of Residence/Address									
City				State			ZIP Code		

I understand that this statement is voluntary and that my signature is required for Blue Cross and Blue Shield of Texas to consider the disability request and to make a determination on whether to grant the disability request for eligibility for the above dependent child. I understand that without my signature no action will be taken.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION 2 — TO BE COMPLETED BY ATTENDING PHYSICIAN** Note: Any fee for the completion of this form is the responsibility of the patient.

Patient's Name			Diagnosis (Be as detailed as possible)						
If the dependent child has ever been under observation, care or treatment in any hospital, sanitarium, asylum or similar institution, please complete the following:									
Name of hospital or institution									
Number of days admitted		Date of last treatment or care			Date of first visit			Frequency of visits	
		MM	DD	YYYY	MM	DD	YYYY	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other	
Extent of Disability					Disability has existed continuously since				
Is patient now incapable of self-support because of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No					MM	DD	YYYY		
When do you think the patient will be able to return to gainful employment?					Approximate Date			<input type="checkbox"/> Indefinite <input type="checkbox"/> Never	
					MM	DD	YYYY		
Physician's Name						Phone Number			
Physician's Street Address									
City						State		ZIP Code	
Physician's Signature							Date		