

Please type or print. The patient is responsible for the completion of this form without expense to Standard Insurance Company.

TO BE COMPLETED BY PARENT

Dependent's Full Legal Name:			
Address:		City:	State: Zip Code:
Birthdate:	Social Security No.:	Phone No.: ()	
Parent's Statement: My Dependents Life Insurance coverage became effective on (give approximate date) _____ and my disabled child became insured as my Dependent on _____, which was before his or her 21st birthday. On my disabled child's 21st birthday, and at all times since then, he or she has been both: (1) Continuously incapable of self-sustaining employment by reason of mental retardation or physical handicap incurred prior to age 21, and (2) Continuously chiefly dependent upon me for support and maintenance or institutionalized because of the mental retardation or physical handicap. My disabled child is unmarried.			
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.			
Parent's Signature:			Dated:
Address:			

TO BE COMPLETED BY PHYSICIAN

Diagnosis: _____ _____
Symptoms: _____ _____
Height of patient: _____ Weight of patient: _____
Objective findings (please forward laboratory data and results of special tests such as x-rays, EKGs, EEGs, etc.) _____ _____
History (please provide a brief history and attach narrative report, physician's notes or operative reports if available) _____ _____ _____

1. INFORMATION

When did symptoms first appear? _____
Date patient first consulted you for this condition: _____
Dates of subsequent treatment (<i>attach statement if convenient</i>): _____
Frequency of treatments: _____
Condition: <input type="checkbox"/> Retrogressed <input type="checkbox"/> Unimproved <input type="checkbox"/> Improved <input type="checkbox"/> Recovered

2. HOSPITAL CONFINEMENT

Name of Hospital: _____	Admitted: _____	Discharged: _____
Reason for Hospitalization: _____		

3. OTHER PHYSICIANS

Name: _____	Specialty: _____		
Address: _____	City: _____	State: _____	Zip Code: _____
Phone No.: ()			

4. PHYSICIAN COMPLETING THIS FORM

Name of Physician: _____	Specialty: _____		
Address: _____	City: _____	State: _____	Zip Code: _____
Phone No.: ()	Fax No.: _____		
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.			
Signature: _____			Date: _____

TO BE COMPLETED BY EMPLOYER

Hire Date of Member (Parent): _____ (<i>please send or fax us a copy of the Member's (Parent's) enrollment form with this form</i>)	
Effective date of Member's (Parent) insurance: _____ Effective date of Dependent's Life Ins. Coverage: _____	
Amount of Dependent's Life coverage: _____	
Employer Name: _____	Policy No.: _____
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.	
Signature: _____	Date: _____
Benefits Contact Name: _____	
Phone No.: ()	

Return to Standard Insurance Company at the address above.