Affidavit of Disability

INTEGRIS Health

Dependent Information

Please provide the following information:

_____ _____
Dependent First Name Last Name

1. Is this dependent single or married? _____

2. Is this dependent currently employed? _____

   - If yes, please provide the name and address of this dependent's current employer:

   _____
   Employer Name

   _____
   Street Address City State Zip Code

   - If no, please provide the date last employed _____

3. Part time ☐ Full time ☐

4. Percentage of dependent support provided by the employee? _____

5. Does the dependent permanently reside with the employee? _____

   – If no, please explain _____

Authorization

I certify that the information regarding my dependent listed above is true and correct. I understand that the information provided is subject to verification and falsifying this information can lead to cancellation of this dependent's coverage.

_____ _____
Employee Signature Date

_____ _____
Employee Name (Print) Employee ID Number

Please mail this affidavit containing dependent information and physician verification to:

INTEGRIS *Health* Human Resources
3400 NW Expressway, Suite 100
Oklahoma City, OK 73112

Physician Verification

Please provide the following information pertinent to this patient's disability:

- Diagnosis of condition causing incapacity status.

_____

_____

1. Is the patient capable of maintaining full or part-time work at any level? Yes ☐ No ☐

2. Is the patient capable of providing self support? Yes ☐ No ☐

_____ _____
Name of Physician Phone number

Physician Address _____
Street

_____
City State Zip Code

Authorization

I certify that the information provided above is true and correct. I also certify that I am aware it is against the law to falsify information or to intentionally exclude the facts I know are essential to the condition of this patient.

_____ _____
Physician Signature Date