DISABILITY QUESTIONNAIRE
(Complete all questions)

Name of primary applicant: ________________________________ ID/SSN: __________________________

Name of person treated/relationship to applicant: ____

1. What is your disability?: ____
   What form of disability do you receive? _____Social Security _____VA
   _____Employer long term _____Employer short term
   _____Other ______________________________________

2. Date diagnosed or date of first symptoms: ____

3. Details including dates of past and current treatment: __________________________________

   ____

4. Any prescription medications taken for this condition? ____yes ____no
   Name of Medication: **Dosage:** **Frequency (ie., daily, as needed)**

   ____

   ____

   ____

5. Give name and address of treating physician: ____

   ____

6. Date last seen for this condition? ____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand that Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

____ ____________________________

Signature of person treated (or parent/guardian if under 18) Date