

**CommunityCare Managed Healthcare Plans of Oklahoma  
Attn: Enrollment Services  
218 W. 6<sup>th</sup> Street  
Tulsa, OK 74119**

**REQUEST FOR DEPENDENT COVERAGE DUE TO INCAPACITATION**

**Employee Name** \_\_\_\_\_

**Employee Address** \_\_\_\_\_

**Employer** \_\_\_\_\_ **Street** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Policy No.** \_\_\_\_\_

**Dependent's Full Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Dependent's Address** \_\_\_\_\_

**Street** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

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**To be completed by the dependent's personal physician**

**Please describe the condition(s) which prevents this child from performing some type of work:**

**Diagnoses:** \_\_\_\_\_

**When was this condition first diagnosed?** \_\_\_\_\_

**When did the patient become totally disabled?** \_\_\_\_\_

**Current physical and mental functional status:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Does this patient have the capacity to become functionally independent?**     **yes**     **no**

**Is the condition(s) presumed to be totally and permanently disabling?**     **yes**     **no**

**If no, what is the estimated length of the disability?** \_\_\_\_\_

**Other pertinent information:** \_\_\_\_\_  
\_\_\_\_\_

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Street** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**If additional space is needed, feel free to write on the back or attach information to this form.**