UnitedHealthcare Oxford

Disability Questionnaire

To Be Completed by the Oxford Plan Subscriber (please print clearly)

Subscriber Name			Oxford Member ID #	
Street Address	Apt #	City	State	ZIP Code

Are you or any of your covered family members disabled? (check one) Yes ___ No ___

If "Yes," please complete the sections below.

Disabled Member's Name	Birthdate Month Day Year

Is the disabled Member covered by any health insurance other than an Oxford plan (including Medicare or Medicaid)? If "Yes," please tell us:

Name of the Other Carrier Effective Date of that Coverage Policy Number

Please enclose a photocopy of the insurance card.

I attest to the best of my knowledge that the information I provided is correct. That (if applicable) the dependent named above (if such dependent is a child aged 26 or older) is unmarried and is chiefly dependent upon me for economic support and maintenance.

_____ _____

Subscriber Signature Date

To Be Completed by Physician (please print clearly)

Disability Diagnosis	Please indicate the status of the disability Temporary _____ Permanent _____
Description of Disability	
Date Disability Commenced	Age At Which Disability Arose

Is the individual listed above capable of self-sustaining employment or attending school on a full-time basis (if 19-25 years of age)?	At this time? YES ___ NO ____	In the future? YES ___ NO ____

If 'No" was checked for any response above, please provide a brief explanation.

Physician Signature: _____ Date: _____

Print Physician Name: _____

Physician Office Address: _____

Please return this completed form to us at:

Oxford Member Enrollment
P.O. Box 29142
Hot Springs, AR 71903