DISABLED DEPENDENT VERIFICATION FORM

Employer Name:	Group Number:
Subscriber/Employee Name:	Member ID#:
Dependent's Name:	Date of birth:
Nature of Disability:	Date in which disability began:

Name and address of Primary Care Physician:

Telephone number where you can be reached: Email address:

I certify that the above information is correct to the best of my knowledge and authorize release of any information request in regard to this certification.

Employee/Subscriber (Parent) Signature: ___________________________________Date___________________

Please return this form to our team via email:

BrightBenefitsEnrollment@skygenusa.com

Any person who knowingly and with the intent to defraud any company or other person files a stamen of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.