
Brown & Brown of New York, Inc. dba
Fitzharris & Company, Inc.

814 Fulton Street
P. O. Box 9182
Farmingdale, NY 11735
Phone: (516) 777-4800
Fax: (516) 777-5777

Date: _____

Employer: _____

Employee: _____

I.D.#: _____

Claimant: _____

Disabled Dependent

Dear: _____

At this time, in order to keep our records up to date, we request additional information regarding the dependent status of

_____.

Kindly have the appropriate doctor complete the enclosed form and return it to Fitzharris & Company, Inc. at your earliest convenience. Please note if you have documentation from your medical insurance carrier verifying the dependent status, a photocopy of such documentation may be substituted.

Thank you for your cooperation. If you have any questions please feel free to call.

Sincerely,

Claims Examiner / Eligibility Dept.

Enc.

cc:file

Attending Physician's Statement

Insured Dependent Child	Child's Birthday
Insured Parent	Group Policy #
Group Policy Holder (full legal name)	

I hereby authorize this undersigned Physician to release any information in the course of examining the child named above.

Date: ___/___/_____

Signed: _____
(Parent, if child is a minor or Incapable)

The insured is responsible for the completion of this form without expense to the company. You may mail this form directly to the current Administrator or Insurance Carrier. If additional space is needed for answers, please use the back of the form.

The child named above is suffering from:

- () Physical disability, Describe below in detail
 () Mental disability, Describe below in detail

Child's present condition is:

- () Ambulatory () Bed Confined () House Confined () Hospital Confined

Disability History:

A. Nature of disability? (describe fully)

B. Cause of disability?

C. Date on which disability began? (birth, or thereafter - specify date)

Beginning Date: ___/___/_____

D. Date on which you were first consulted?

E. Do you expect this to be permanent?

() Yes, please explain _____

() No - please provide the date through which the disability is expected to continue: ___/___/_____

F. What is your diagnosis?

G. Does this disability presently render the child incapable of self-sustaining employment?

H. Further Comments:

Date

Signature of Attending Physician

Degree

Telephone Number

Street Address

City/Town

State

Zip Code