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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

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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 as described more fully in Section 1 below  
 ( ) Mental disability as described more fully in Section 2 below

Child's present condition is:

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

1. Physical Disability

- A. Nature of disability? (describe fully) \_\_\_\_\_
- B. Cause of disability? \_\_\_\_\_
- C. Date disability began? (birth, or thereafter - specify date) \_\_\_\_\_
- D. Date on which you were first consulted? \_\_\_\_\_
- E. Do you expect this to be permanent? ( ) Yes, please explain ( ) No \_\_\_\_\_
- F. What is your diagnosis? \_\_\_\_\_
- G. Does this disability presently render the child incapable of self-sustaining employment? \_\_\_\_\_
- H. Further Comments: \_\_\_\_\_

2. Mental Disability

- A. Nature of disability? (describe fully) \_\_\_\_\_
- B. Cause of disability? \_\_\_\_\_
- C. Date on which disability began? (birth, or thereafter - specify date) \_\_\_\_\_
- D. Date on which you were first consulted? \_\_\_\_\_
- E. What psychological, psychometric, or psychiatric tests were given in the diagnosis? (list fully) \_\_\_\_\_
- F. What were the results of the tests listed in Section E above? \_\_\_\_\_
- G. What is your prognosis? \_\_\_\_\_
- H. Does this disability presently render the child incapable of self-sustaining employment?  
 ( ) Yes ( ) No \_\_\_\_\_
- I. Further Comments: \_\_\_\_\_

_____	_____	_____	_____
Date	Signature of Attending Physician	Degree	Telephone Number
_____	_____	_____	_____
Street Address	City/Town	State	Zip Code