



7510 Shoreline Drive
Stockton, CA 95219
Toll Free (800) 350-3989
Fax (209) 478-5614

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 Cypress Ancillary Benefits via one of the following methods:

1. Email to: enrollment@cyressadmin.com
2. FAX to: 209-478-5614 to the attention of Student Verification Department
3. Mail to: Cypress Ancillary Benefits

Attn: Student Verification Department
7510 Shoreline Drive
Stockton, CA 95219

Any person who knowingly and with the intent to defraud any company or other person files a statement 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.

BETTER BENEFITS. BETTER YOU.

