BlueCross BlueShield Minnesota

Incapacitated Dependent Certification

Birmingham Service Center
Attention: Enrollment Services
PO Box 10527
Birmingham, Alabama 35202-0500

Employee: Please read the conditions of eligibility below, complete this form and sign it. Then, ask your dependent's physician to complete, sign and mail the completed form to the address above, right.

CONDITIONS OF ELIGIBILITY FOR AN INCAPACITATED DEPENDENT OVER THE AGE LIMIT IN YOUR CONTRACT PLAN

Subject to provisions in the employee's Contract or Plan, an incapacitated dependent will be considered for coverage to any age provided the dependent

- is unmarried,
- is mentally or physically disabled or incapacitated,
- is so incapacitated as to be incapable of self-sustaining employment,
- is dependent upon the employee for support and maintenance and lives with the employee in a regular parent-child relationship,
- and the condition must have occurred prior to the dependent's attaining 26 years of age or the age as specified in the employee's Contract or Plan.

Neither a reduction in work capacity nor inability to find employment are, of themselves, evidence of eligibility. If a mentally or physically disabled dependent is working, despite his disability, the extent of his earning capacity will be evaluated. To apply for eligibility for a dependent under this provision, this form must be certified by the employee and the dependent's attending physician and submitted to Blue Cross and Blue Shield of Minnesota 60 days in advance of the effective date of extension of coverage.

EMPLOYEE *(Please type or print)*

Dependent Child's Name *(Last, First, Initial)*	**Child's Sex** ☐ Male ☐ Female	**Dependent Date of Birth** M M / D D / Y Y Y Y
Dependent Child's Social Security Number ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___	**Relationship to Employee**	
Employee's Name *(Last, First, Initial)*	**Contract Number**	
Social Security Number ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___	**Group Number** (if shown on ID Card) ___ ___ ___ ___ ___	**Name of Employee's Employer**
Employee's Street Address, City, State and ZIP	**Child's marital status** ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
Date child's disability occurred M M / D D / Y Y Y Y	**Is child permanently residing in your household?** ☐ Yes ☐ No *(explain):*	**Is child dependent on you for support?** ☐ Yes ☐ No

If "Yes" what part of support do you contribute? *(% of total)*	**Was child taken as a dependent on your last income tax return?** ☐ Yes ☐ No	**Was child ever employed?** ☐ Yes ☐ No	**Is child employed?** ☐ Yes ☐ No

If answer to either of the last two questions is "Yes': give name(s), address(es) of employer(s) and date(s) employed

Is dependent eligible for any other care under federal, state or local law? ☐ Yes ☐ No	**Do you, your spouse, or the dependent have other health care coverage?** ☐ Yes ☐ No

If "Yes" give name and address of other insurance company

I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge. I hereby authorize any physician or other person who has attended my above named dependent child or who may hereafter attend or examine such child to disclose any knowledge or information thereby acquired by him to Blue Cross and Blue Shield of Minnesota. Any charges for providing this information will be my responsibility. I understand that enrollment for this child under my coverage may remain in force so long as this dependency exists and while my coverage is of the type which may include such a dependent child. I further understand that Blue Cross shall have the right to require recertification as to eligibility for continuation of dependency coverage as often as Blue Cross may reasonably require.

	M M / D D / Y Y Y Y	
Signature of Employee	Date	Contract Number

DEPENDENT *(Please type or print)*

Dependent Name *(Last, First, Initial)*	**Dependent Date of Birth** M M / D D / Y Y Y Y

PHYSICIAN'S QUESTIONNAIRE — This section is to be completed by dependent child's attending physician.

1. On what date did the dependent's disability occur? M M / D D / Y Y Y Y

2. Describe the nature of the dependent's disability and give a brief assessment of his/her prognosis.

_____

_____

3. Has the dependent's disability existed continuously up to the present? ☐ **YES** ☐ **NO**

4. Do you consider the disability to be permanent?

☐ **YES**

☐ **NO**; I estimate the length of disability at _____ ☐ months / ☐ years

5. Is the dependent able to perform the basic activities of daily living; i.e., independent feeding, dressing, performing personal hygiene, and grooming?

☐ **YES** ☐ **NO**

6. Is the dependent capable of managing toilet activities? ☐ **YES** ☐ **NO**

7. Does the dependent suffer with a ***severe organic psychiatric disease*** which results in one or more of the following:
(Please check those descriptions which are applicable and comment if necessary)

- ☐ Unmanageable hallucinations, loss of touch with reality, paranoia, and/or other severe dysfunctional behaviors
- ☐ Repeated destructive behavior towards self, others, and/or property.
- ☐ Severe impairment of mobility with physical and/or mental inability to use adaptive equipment, such as walkers, crutches, wheelchairs, etc.
- ☐ Chronic and/or long-term disease or injury, impairing ability to work or attend school during the recuperative period of the disease or injury.
- ☐ Severe or profound mental retardation as defined by confirmed I.Q. test scoring.
  (List below the results of the most recent I.Q. testing.)

Your Comments:

_____

_____

_____

_____

_____

PLEASE ATTACH A COPY OF YOUR MORE RECENT MEDICAL RECORDS FOR THIS PATIENT.

Physician's Street Address, City, State, ZIP		M M / D D / Y Y Y Y
_____	**Physician's Signature**	**Date Signed**