



REPLY MUST BE RECEIVED WITHIN 30 DAYS OF ISSUE DATE

Dependent:

ID #:

GROUP:

Dear:

Your plan provides benefits for the customer, the customer's spouse and children to the age specified in your plan. Dependent children, who are permanently disabled, by mental or physical handicap, occurring prior to the limiting age, may also be eligible for benefits. If your dependent has been approved by the government to receive Social Security benefits or SSI, it is not necessary to provide the information from the attending physician. We only require you to provide us with proof of that coverage and return it with this completed letter. It is important to note, handicapped dependents, must qualify as a Federal Tax Exemption, to be covered on your plan.

We need the following questions answered, in order to verify this dependent's eligibility for benefits, under your plan. You can assist us by answering the following questions, signing the form and promptly returning this form and all supporting documentation, to our office, in the envelope provided.

Dependent's Name:

Date of Birth:

Dependent's relationship to the customer: \_\_\_\_\_

Is the above named dependent employed? Yes \_\_\_\_\_ No \_\_\_\_\_ Full-time \_\_\_\_\_ Part-time \_\_\_\_\_

Marital status of dependent: Single \_\_\_\_\_ Married \_\_\_\_\_

If not enrolled now, will he or she be enrolled as a full-time student in a recognized course of study or training?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, name of school: \_\_\_\_\_

Is the dependent wholly dependent on the customer for support? Yes \_\_\_\_\_ No \_\_\_\_\_

Is the dependent permanently residing in your household? Yes \_\_\_\_\_ No \_\_\_\_\_

Is the dependent covered under any other employer group insurance or prepayment program? Yes \_\_\_\_\_ No \_\_\_\_\_

Is this dependent mentally or physically disabled? Yes \_\_\_\_\_ No \_\_\_\_\_ (If Yes, see attachment.)

Is the dependent allowed as an income tax exemption? \_\_\_\_\_ If yes, for how many years? If no, what was the last calendar year you claimed the above dependent on your Federal Income Tax? \_\_\_\_\_

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS RECERTIFICATION.

Signature of Participant \_\_\_\_\_ Date Signed \_\_\_\_\_

National Accounts Membership/OH93A-740

**APPLICATION FOR CONTINUATION OF COVERAGE  
ANTHEM BLUE CROSS AND BLUE SHIELD  
6740 NORTH HIGH STREET  
WORTHINGTON, OHIO 43085  
ATTN: NATIONAL ENROLLMENT**

**For A Child Who Is Incapable of Self-sustaining Employment By Reason of Mental Or Physical Handicap And Who Has Reached The Limiting Age  
For Dependent Children Specified In The Contract.**

Please read conditions of eligibility on previous page

Please type or Print

**SECTION I TO COMPLETED BY CUSTOMER**

Dependent Child's name (Last, First, Initial)	Child's Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Child's Birthday Month Day Year. 	Relationship to customer
Customer's Name (last, First, Initial)	Identification #	Group # (If it appears on ID card)	Name of Customer's employer
Customer's Address (Number, Street City, State & Zip Code)			

Child's Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	Date Child's disability Occurred	Is child permanently residing in your household? Yes <input type="checkbox"/> If "No" Please explain No <input type="checkbox"/>	
Is child dependent on you for support? Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes" what part of support do you contribute? (% of total)	Was the child taken as a dependent on your last income tax return? Yes <input type="checkbox"/> No <input type="checkbox"/>	Was the child ever employed Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the child employed now? Yes <input type="checkbox"/> No <input type="checkbox"/>	If the answer to either of the last questions is "yes", please give then name(s),address(es) of employer(s) and date(s) employed		
Is the dependent eligible for any other care under federal, state or local law? Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes" please give details		
Do you or your spouse have other health care coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes" give name and address of 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 the Blue Cross Plan stated above.

Date	Signature of Subscriber	Soc. Sec. No. of subscriber
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**SECTION II - TO BE COMPLETED BY ATTENDING PHYSICIAN**

HAS THE CHILD'S DISABILITY EXISTED CONTINUOUSLY UP TO THE PRESENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	Date the child's disability occurred	What is the child's IQ?	Prognosis (estimate months or years)	Is the child now incapable of self- support because of the disability? Yes <input type="checkbox"/> No <input type="checkbox"/>
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Nature of disability (please give as much details as practicable) - Use other side of sheet if necessary. Please include all applicable ICD-9 codes

Date	
Signature of Physician	
Physician's Address	

Dependent Name : ID :

To physician: Please return form directly to the Blue Cross plan named above