

# APPLICATION TO CONTINUE COVERAGE FOR HANDICAPPED DEPENDENT CHILD



Subscriber's Name \_\_\_\_\_ Group No. \_\_\_\_\_ Identification No. \_\_\_\_\_

Street Address \_\_\_\_\_ Employee's Name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Employer's Address \_\_\_\_\_

## I HEREBY APPLY FOR CONTINUATION OF COVERAGE FOR THE FOLLOWING CHILD UNDER MY SUBSCRIPTION AGREEMENT(S):

Name of Dependent (Last Name, First Name, Middle Initials)

\_\_\_\_\_

Dependent's Birthdate \_\_\_\_\_

Relationship to Subscriber \_\_\_\_\_ Is Dependent Married? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is Dependent Receiving Benefits?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Is Dependent Covered by Medicare?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Is Dependent receiving Social Security Benefits?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If your dependent is presently enrolled under his/her own Blue Cross and/or Blue Shield Agreement(s), give:

Group Number \_\_\_\_\_ Identification Number \_\_\_\_\_ Location of Plan \_\_\_\_\_

I hereby certify that the above child is unmarried, is incapable of self-support, is in fact dependent upon me for over half of his or her support and that my child's disability commenced prior to attaining 19 years of age.

I understand and agree as follows: That the requested coverage for the above child shall not become effective unless and until this application is accepted and approved by Independence Blue Cross and thereafter may be revoked by Independence Blue Cross if any of the statements made herein are incorrect or if Independence Blue Cross later determines that the above dependent no longer qualifies for coverage as a handicapped dependent; That this application will become a part of my original application and will be subject to the terms of my Subscription Agreement(s); That acceptance of this application does not confer eligibility upon the above child for Major Medical benefits unless the group application describing the Major Medical Program so stipulates.

I further understand and agree that Independence Blue Cross reserves the right to request additional documentation if required.

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

**APPLICATION TO CONTINUE COVERAGE  
FOR HANDICAPPED DEPENDENT CHILD**

Certification of Attending Physician  
(must be completed by attending physician)

Physician's Name \_\_\_\_\_ Degree/Specialty \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

1. The above patient is presently under my care:  
\_\_\_\_\_ Yes \_\_\_\_\_ No

2. Date dependent was last treated \_\_\_\_\_

3. Diagnosis and concurrent conditions  
\_\_\_\_\_  
\_\_\_\_\_

4. Has such disability existed continuously since before dependent attained age 19?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

5. Has dependent been confined to a hospital as a result of this disability? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, give name and address of hospital:

\_\_\_\_\_  
\_\_\_\_\_

Date Admitted \_\_\_\_\_ Date Released \_\_\_\_\_

6. Nature of Treatment

A. Medication - i.e., dosage, frequency  
(Please list) \_\_\_\_\_  
\_\_\_\_\_

B. Care Plan: \_\_\_\_\_  
\_\_\_\_\_

C. Compliance with Prescribed Treatment  
\_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

7. Prognosis

Is dependent totally disabled and incapable of self-support?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

If not totally disabled, is dependent capable of self-support?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

Do you expect a fundamental or marked change in the dependent's condition in the future?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, when will patient recover sufficiently to be capable of self-support?

\_\_\_\_\_  
\_\_\_\_\_

If so, please explain: \_\_\_\_\_  
\_\_\_\_\_

8. Additional Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_