



Adult Disabled Dependent Form Employer Group

Instructions for the Subscriber:

- Please apply for coverage within 31 days of your disabled dependent aging off your policy
- Complete Sections 1, 2 and the dependent information above Section 3
- Sign the bottom of page 2
- Forward Section 3 to your dependent's doctor
- Once complete and returned to you, mail the original form to Excellus BlueCross BlueShield
P.O. Box 21146, Eagan, MN 55121
- Send a copy of the form to your employer

The following information is required to determine whether your dependent is eligible for coverage.

Section 1: SUBSCRIBER INFORMATION - Completed by Subscriber

Last Name:	First Name:	MI:
Street:		
City:	State:	ZIP:
Subscriber ID:	Phone: () -	

Section 2: DEPENDENT INFORMATION - Completed by Subscriber

Dependent Last Name:	First Name:	MI:
Does Dependent live with the Subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain and provide address below:		
Street:		
City:	State:	ZIP:
Date of Birth (MM/DD/YYYY):		
Relationship to Subscriber: <input type="checkbox"/> Child (natural or adopted) <input type="checkbox"/> Stepchild <input type="checkbox"/> Legal Guardianship		
Is Dependent presently married? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Additional Coverage Information for Dependent:

Include any other source of coverage for the dependent, including federal, state, local, other commercial health insurance and Medicare.

Medicare Number (if applicable):	Part A Effective Date	Part B Effective Date
	/	/

Medicaid or other governmental coverage if applicable

Coverage issued through:	ID# (if applicable):	Effective Date	Termination Date
		/	/

Medicaid or other governmental coverage if applicable

Coverage issued through:	ID# (if applicable):	Effective Date	Termination Date
		/	/
		/	/

I request coverage under my policy for my adult disabled dependent named on this form. I understand that their enrollment may be continued only as long as they are:

- Unmarried
- Incapable of self-sustaining employment by reason of: mental illness, developmental disability, intellectual disability, cerebral palsy, Down Syndrome, autism spectrum disorders, neurological impairments or physical handicap
- Financially dependent on me for 50% or more of their support, and
- Continuously covered under my policy after the date they would otherwise age off the policy.

I also understand that:

- I'll inform Excellus BlueCross BlueShield of any changes in the status of my dependent's disability or eligibility for coverage (for example, marriage) and that
- Excellus BlueCross BlueShield has the right to require periodic recertification of my dependent's ongoing eligibility for coverage as a disabled dependent.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Subscriber Signature:	Date:
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Dependent Information (subscriber, please repeat information from page 1):		
Last Name:	First Name:	MI:
Street:		
Date of Birth (MM/DD/YYYY):	Sex:	

Instructions for the Physician:

This form is to determine whether your patient is eligible for coverage beyond the date that they will otherwise age off the policy. Thank you in advance for your prompt and thorough attention to this form on behalf of your patient as it is a critical for the determination.

- Complete and sign Section 3
- Attach any applicable documentation to support status (i.e. clinical summary)
- Return the original to the subscriber

Section 3: MEDICAL INFORMATION - COMPLETED BY ATTENDING PROVIDER (MD, DO, NP or PA):

1. Diagnosis (Please use standard nomenclature):
2. If physically disabled, was this the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. If mental illness*, describe limitations:
If 2 or 3, describe treatment and rehabilitation currently received by patient:
Has there been IQ or other testing? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please submit summary with this form.
*Please attach a copy of patient's last psychological evaluation, WAIS and/or MMPI report

Is your patient able to:											
Yes	No		Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Feed Self	<input type="checkbox"/>	<input type="checkbox"/>	Dress Self	<input type="checkbox"/>	<input type="checkbox"/>	Bathe Self	<input type="checkbox"/>	<input type="checkbox"/>	Toilet Self
<input type="checkbox"/>	<input type="checkbox"/>	Read	<input type="checkbox"/>	<input type="checkbox"/>	Write	<input type="checkbox"/>	<input type="checkbox"/>	Speak	<input type="checkbox"/>	<input type="checkbox"/>	Handle Money
<input type="checkbox"/>	<input type="checkbox"/>	Drive Vehicle	<input type="checkbox"/>	<input type="checkbox"/>	Ambulate Independently	<input type="checkbox"/>	<input type="checkbox"/>	Transfer Self, bed to chair	<input type="checkbox"/>	<input type="checkbox"/>	Use Public Transportation

To your knowledge, the length of time this disability has existed:
 Congenital or Date of Onset: _____

Probable future course and duration: _____

Does patient currently reside in a group home or health care facility? Yes No

If yes, provide name of facility: _____

In your professional opinion, can this patient currently engage in self-supporting employment?
 Yes No

In what timeframe do you expect your patient to be self-sufficient?

Please elaborate on the reason(s) for your answer: _____

I certify that this patient is presently under my care and that I see this patient on a regular ongoing basis.

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Physician Signature:	Date:
Name of Physician (please print):	Phone: ()
Physician's Address:	

Office Use Only:			
<input type="checkbox"/> Not Approved	Date:	Reviewer:	
	Reason:		
<input type="checkbox"/> Approved	Date:	Reviewer:	
	Effective Date:	Medical Recertification Date:	
	Reason		
	Eligibility Recertification Date:		
	Processed By:	Date:	