

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?

Is Dependent Covered by
Medicare?

Is Dependent receiving
Social Security Benefits?

_____ Yes _____ No

_____ Yes _____ No

_____ 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 _____