

# Request for Certification for a Mentally or Physically Incapacitated Dependent Child



**Important:** If you are transferring from another insurance carrier and the child is over nineteen years of age written documentation is required from your prior carrier which states that:

- \* Dependent Child was covered on a continual basis
- \* Coverage was in effect up to the date of insured's Anthem Blue Cross and Blue Shield (Anthem BCBS) coverage.

Section 1 — Subscriber and Dependent Child Information:			
Name of Subscriber:	Street Address:	City:	State / Zip:
Subscriber's Social Security Number:	Subscriber's Certificate Number:	Name of Employer:	Division Number:
Name of Dependent Child to be Covered:	Street Address if different:	City:	State / Zip:
Dependent Child's Birth Date: Mo          Day          Yr	Dependent Child's Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		

Is the Dependent Child Employed for Wages?     No     Yes  
If yes, give name of employer and approximate number of hours worked per week:

Employer Name: \_\_\_\_\_ Number of Hours Worked: \_\_\_\_\_

Is the Dependent Child confined to an institution or attending school?     No     Yes  
If yes, give name of institution or school and date of admission:

Name of Institution or School: \_\_\_\_\_ Date of Admission: \_\_\_\_\_

Is the above-named dependent receiving Medicare benefits?     No     Yes  
If yes, include copy of Medicare Card or SSI Benefits with application.

Is the above-named dependent receiving Medicaid benefits?     No     Yes  
If yes, include copy of Medicaid Card with application.

Has the Dependent Child applied for SSI benefits?     No     Yes    Date of Application: \_\_\_\_\_

What is the length of time that this disability has existed? \_\_\_\_\_ Start Date: \_\_\_\_\_

## Section 2 — Parent or Legal Guardian Signature:

I am requesting that the above mentioned Child be included under my Anthem BCBS membership. I understand that this Child may be covered under my membership only so long as:

- \* The Child is incapable of self-support because of a physical or mental incapacity which existed prior to age nineteen (19), and
- \* I furnish more than one-half of this Child's support.

I further understand that:

- \* It is the responsibility of the applicant to notify Anthem Blue Cross and Blue Shield of any change in the status of the dependent's incapacity, and that
- \* Anthem Blue Cross and Blue Shield shall have the right to require recertification as to the eligibility for continuation of coverage as an incapacitated dependent.

If you have additional questions, or need assistance in completing this form, please contact your group's benefit administrator or the Customer Service number listed on your Anthem BCBS ID Card.

The information I have supplied above, is true and to the best of my knowledge, is correct.

I certify that the above statements are true and complete to the best of my knowledge and belief.

Subscriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Before you return the certification, have you:

- Completed and verified all information and sections of this application?
- Read and signed Section 2?
- Read and understood all sections?
- If Dependent is over 19 years of age and you are transferring from another insurance carrier, have you supplied written documentation of prior coverage up to the effective date of Anthem BCBS coverage?
- Submit this form to the dependent child's attending physician for completion and signature.

### Please return to the address below:

Anthem Blue Cross and Blue Shield, Attn: Enrollment Department, 3000 Goffs Falls Road, Manchester NH 03111-0001

**Questions? Call the Customer Service number on your ID card.**

# Incapacitated Dependent Child Authorization Form

The following authorization must be signed by the incapacitated dependent child ("Applicant") or his/her legal representative to be covered. If the Applicant does not sign this authorization, coverage cannot be issued.

*I hereby authorize that:*

- 1. At the request of Anthem Blue Cross and Blue Shield, any provider of health services or supplies, insurance company, organization, institution, or person may release information to Anthem Blue Cross and Blue Shield about health-related services and supplies provided to me. This authorization shall not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the rest of the provider's medical record;*
- 2. the Medical Review and Underwriting departments or agents of Anthem Blue Cross and Blue Shield, upon receiving this information, may use it to review, investigate, or evaluate any application for an insurance policy, a policy reinstatement, or a request for change in policy benefits;*
- 3. unless I revoke this authorization, this authorization is valid for 24 months from the date I signed it; and*
- 4. a copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.*

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Signature of Applicant or Legal Representative, if applicable

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Date

If a legal representative signs on behalf of the Applicant, a copy of the legal representative's authority must be attached to this authorization.

This authorization is subject to revocation at any time by written notice to Anthem Blue Cross and Blue Shield except to the extent that Anthem Blue Cross and Blue Shield has already taken action in reliance on this authorization. Any information received by Anthem Blue Cross and Blue Shield pursuant to this authorization is subject to restrictions on disclosure to others as set forth under applicable federal and state laws.

