Request to Continue Dependent Coverage

Anthem

Your request cannot be processed if any information is missing.

Please fill in all sections on both pages completely and mail to:

Anthem Blue Cross
Select street address
Select City, State, ZIP code

Select fax number

Section 1: Subscriber information

Last name	First name	M.I.	Member ID no.
Street address	City	State	ZIP code
Phone no.	Employer name	Group no.	

Section 2: Dependent information

Last name	First name	M.I.	Date of birth (MMDDYYYY)
Social Security no.	Gender ☐ Male ☐ Female	Marital status ☐ Married ☐ Single	Relationship to subscriber
Type of impairment or injury			Date of impairment or injury

Does the subscriber claim the dependent for income tax purposes? ☐ Yes ☐ No
Does the dependent live with the subscriber? ☐ Yes ☐ No
If **no** to either question, please explain: _____

Section 3: Additional insurance policies for this dependent

Does the dependent have another health plan? ☐ Yes ☐ No
Will your Anthem policy replace their other insurance? ☐ Yes ☐ No
If **yes** to either question, complete the following.

Other plan's policyholder name		Date of birth (MMDDYYYY)	Policy no.
Health insurance company name		Other plan phone no.	Other plan group no.
RX Bin	RX PCN	Date coverage started	Date coverage ended

How did they get these benefits? ☐ Through employer ☐ As individual ☐ Another way – describe: _____

Is the dependent currently receiving Social Security benefits? ☐ Yes ☐ No
If **yes**, what was the effective date? _____ If **no**, have benefits been denied? ☐ Yes ☐ No

Medicare – Answer these questions if their other health plan is Medicare.

Name of Medicare cardholder	Medicare claim ID/no.	Effective dates for each part	Medicare entitlement reason
		A: _____ B: _____ C: _____	☐ Age ☐ Disability ☐ ESRD*

*If ESRD (kidney or renal failure) is the primary reason for Medicare, provide the date of first dialysis treatment: _____
and transplant date if applicable: _____

Signature required

I certify that the above information is correct and authorize the release of medical information requested with respect to this certification.

Signature of subscriber **X**	Date (MMDDYYYY)

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Section 4: Diagnosis/Prognosis — Must be completed and certified by a physician.

Diagnosis	ICD-10 code(s)
Describe the dependent's limitations in performing daily activities and ability to manage their affairs	
In your opinion, is the above named dependent currently incapable of self-sustained employment? ☐ **Yes** ☐ **No**	
In your opinion, will the dependent ever be capable of self-sustained employment? ☐ **Yes** ☐ **No** **If "Yes," provide estimated date of return to full functionality:** (MMDDYYYY)	

Physician name	Physician signature **X**	Date (MMDDYYYY)

Physician street address	City	State	ZIP code

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