

«CURDAT»

«SUBNAM»
«SUBAD1»
«SUBAD2»
«SUBCSZ»

Dear «SUBNAM»:

Your child may be eligible for dependent coverage under the «GRPNAM» due to a disability. The plan document states the following.

An unmarried Child who is a Dependent and who exceeds the Plan's limiting age for Dependent Children will be eligible for coverage if he, prior to turning age 26, is incapable of self-sustaining employment and is dependent upon you for support due to a mental or physical disability.

Notification of incapacitation must be provided within thirty-one (31) days after the Dependent Child attains age 26, or in the case of a newly-added Dependent Child older than age 26, within thirty-one (31) days after the Effective Date. Failure to provide notification of incapacitation within the timeframe stated above will result in loss of coverage for the Dependent Child. However, he may be re-enrolled in the Plan during an open enrollment period.

Proof of incapacitation will be required to determine whether or not the Dependent Child qualifies as disabled and may be required on an annual basis.

Enclosed are two questionnaires – the first should be filled out by you and the second should be filled out by your dependent's physician.

Please mail or fax the requested information along with a copy of this letter to the address below:

Claims Office
P.O. Box 25946
Overland Park, KS 66225-5946

FAX: 888-860-6962

Once our review is complete, you will be notified of your dependent's eligibility status as a disabled dependent.

We thank you for your cooperation in order to make a complete and thorough assessment.

bcbsil.com



DISABLED DEPENDENT CERTIFICATION

Date:

1. Name of Employee (Print – last, first & middle initial) NAME:		1a. Blue Cross Blue Shield Numbers Group Number: Member ID Number:	
2. Employee's Address (number, street, city, state & zip code) Address:			
3. Dependent's Name Name:	3a. Dependent's Birthdate (Month, Day, Year) / /	3b. Dependent's Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
3c. Dependent's Relationship to Employee	3d. Dependent's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	3e. Dependent's Age When Disability Occurred	

4. Is dependent permanently residing in your household? Yes No - If 'No', please explain on reverse side
5. Is this person dependent upon you for support? Yes No
If 'Yes', what percentage of support do you contribute? _____ %
- 5a. Is dependent listed as a dependent on your last Federal Income Tax Return? Yes No
6. Was dependent ever employed? Yes No
- 6a. Is dependent now employed? Yes No
7. Was dependent covered under your present employer's insurance program immediately prior to attainment of age 26?
 Yes No
8. Is dependent now covered under Medicare or any other hospital-medical coverage? Yes No
- 8a. If answer is 'Yes', furnish name of insurance company and group, certificate or agreement number on reverse side of this form.

Upon presentation of the original or a photo-copy of this signed authorization, I authorize any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, or other person or firm to provide Blue Cross and Blue Shield information, including copies of records, concerning advice, care or treatment provided to the dependent named above including, without limitation, information relating to mental illness, use of drugs or alcohol.

I understand that such information will be used by Blue Cross and Blue Shield for the purpose of certifying the above name dependent as disabled for purpose of coverage under my health insurance. I understand that I or any other authorized representative will receive a copy of this authorization upon request.

This authorization is valid from the date signed for a period of two and one-half years.

I certify that the above information is correct and to the best of my knowledge and belief.

Signature of Employee

Date Signed

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