Anthem Blue Cross and Blue Shield
6740 North High St.
Worthington, OH 43085

Anthem

Date

REPLY MUST BE RECEIVED WITHIN 30 DAYS OF ISSUE DATE

Dependent:
ID #:
Dear: **GROUP:**

Your plan provides benefits for the customer, the customer's spouse and children to the age specified in your plan. Dependent children, who are permanently disabled, by mental or physical handicap, occurring prior to the limiting age, may also be eligible for benefits. If your dependent has been approved by the government to receive Social Security benefits or SSI, it is not necessary to provide the information from the attending physician. We only require you to provide us with proof of that coverage and return it with this completed letter. It is important to note, handicapped dependents, must qualify as a Federal Tax Exemption, to be covered on your plan.

We need the following questions answered, in order to verify this dependent's eligibility for benefits, under your plan. You can assist us by answering the following questions, signing the form and promptly returning this form and all supporting documentation, to our office, in the envelope provided.

Dependent's Name: **Date of Birth:**

Dependent's relationship to the customer: _____

Is the above named dependent employed? Yes _____ No _____ Full-time _____ Part-time _____

Marital status of dependent: Single _____ Married _____

If not enrolled now, will he or she be enrolled as a full-time student in a recognized course of study or training? Yes _____ No _____ If Yes, name of school: _____

Is the dependent wholly dependent on the customer for support? Yes _____ No _____

Is the dependent permanently residing in your household? Yes _____ No _____

Is the dependent covered under any other employer group insurance or prepayment program? Yes ____ No ____

Is this dependent mentally or physically disabled? Yes _____ No _____ (If Yes, see attachment.)

Is the dependent allowed as an income tax exemption? _____ If yes, for how many years? If no, what was the last calendar year you claimed the above dependent on your Federal Income Tax? _____

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS RECERTIFICATION.

Signature of Participant _____Date Signed_____

National Accounts Membership/OH93A-740

APPLICATION FOR CONTINUATION OF COVERAGE
ANTHEM BLUE CROSS AND BLUE SHIELD
6740 NORTH HIGH STREET
WORTHINGTON, OHIO 43085
ATTN: NATIONAL ENROLLMENT

For A Child Who Is Incapable of Self-sustaining Employment By Reason of Mental Or Physical Handicap And Who Has Reached The Limiting Age For Dependent Children Specified In The Contract.

Please read conditions of eligibility on previous page — Please type or Print

SECTION I TO COMPLETED BY CUSTOMER

Dependent Child's name (Last, First, Initial)	Child's Sex Male [ ] Female [ ]	Child's Birthday Month Day Year. | |	Relationship to customer
Customer's Name (last, First, Initial)	Identification #	Group # (If it appears on ID card)	Name of Customer's employer
Customer's Address (Number, Street City, State & Zip Code)			

Child's Marital Status	Date Child's disability Occurred	Is child permanently residing in your household?	
Single [ ] Widowed [ ] Married [ ] Divorced [ ]		Yes [ ] If "No" Please explain No [ ]	
Is child dependent on you for support? Yes [ ] No [ ]	If "Yes" what part of support do you contribute? (% of total)	Was the child taken as a dependent on your last income tax return? Yes [ ] No [ ]	Was the child ever employed Yes [ ] No [ ]
Is the child employed now? Yes [ ] No [ ]	If the answer to either of the last questions is "yes", please give then name(s),address(es) of employer(s) and date(s) employed		
Is the dependent eligible for any other care under federal, state or local law? Yes [ ] No [ ]	If "Yes" please give details		
Do you or your spouse have other health care coverage? Yes [ ] No [ ]	If "Yes" give name and address of Insurance company		

I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge. I hereby authorize any physician or other person who has attended my above named dependent child or who may hereafter attend or examine such child to disclose any knowledge or information thereby acquired by him to the Blue Cross Plan stated above.

Date	Signature of Subscriber	Soc. Sec. No. of subscriber

SECTION II - TO BE COMPLETED BY ATTENDING PHYSICIAN

HAS THE CHILD'S DISABILITY EXISTED CONTINUOUSLY UP TO THE PRESENT? YES [ ] NO [ ]	Date the child's disability occurred	What is the child's IQ?	Prognosis (estimate months or years)	Is the child now incapable of self-support because of the disability? Yes [ ] No [ ]

Nature of disability (please give as much details as practicable) - Use other side of sheet if necessary. Please include all applicable ICD-9 codes

	Date
	Signature of Physician
	Physician's Address

To physician: Please return form directly to the Blue Cross plan named above

Dependent Name : **ID :**