APPLICATION TO CONTINUE COVERAGE
FOR HANDICAPPED DEPENDENT CHILD

Member name:______________________________ Identification No.: _____________________________
Street address: ______________________________ City: _________________ State: _____ Zip:________

Employer's name: ____________________________Employer's address: _________________________ City:
________________ State: _____ Zip: ________

I HEREBY APPLY FOR CONTINUATION OF COVERAGE FOR THE FOLLOWING CHILD UNDER MY SUBSCRIPTION AGREEMENT(S):

Name of dependent: ___________________________________ Birthdate: ___________________________
Relationship to member: _________________________ Is dependent married?: Yes______ No______

Is the dependent: a. Receiving benefits Yes_______ No_______
b. Covered by Medicare Yes_______ No_______
c. Receiving Social Security benefits Yes_______ No_______
(If yes, please attach copy of "Notice of Award" or most recent notice of benefit changes)

Is dependent currently covered as a handicap/disabled dependent by another carrier? Yes_____ No________ (if yes provide carrier name and ID number: ____.

Why are you applying for continuation of benefits for the dependent at this time ________________________
____.

Can dependent perform Activities of Daily Living (i.e. bathing, dressing, eating)? Yes______ No_______
Can dependent travel to and from a destination unattended? Yes_______ No_______
Does dependent work for wages? Yes_______ No_______
What are the specific ways in which you support / assist the dependent
____
____.

If your dependent is presently enrolled under his/her own Independence Blue Cross Agreement, give:

ID No.: _____________________ Group Plan No.: ___________________ Location: ________________________

I hereby certify that the above child is unmarried, is incapable of self-support, is dependent upon me for more than half of his or her support and that his or her disability commenced prior to age 19.
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 herin 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); and; that acceptance of this application does not confer eligibility upon the above child for Major Medical benefits unless the group agreement 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: ___________________________

Please send completed form to:
Independence Blue Cross
c/o Enrollment Services
1901 Market Street
Philadelphia, PA 19103

APPLICATION TO CONTINUE COVERAGE
FOR HANDICAPPED DEPENDENT CHILD
Certification of Attending Physician
(Must be completed by attending physician)

Note: Any fee for the completion of this form is the responsibility of the member.

Physician's name: ______________________________________ Degree/Specialty: _______________________________

Address: ____ City: __________________________ State: _____ Zip: ______

Phone: ____

1. The noted patient is presently under my care Yes______ No_______
2. Date dependent was last treated: ____

3. Diagnosis and concurrent conditions resulting in disability: ____
If mentally impaired, define mental impairment in terms of mental age ______, IQ ____, or functional capacity in work, educational, or social setting ____
____.

If physically impaired, define physical impairment in terms of capacity to perform activities normally performed by individuals of comparable age, intellectual capacity__________________________________
____
____.

Is condition temporary or permanent________________ static or progressive _________

4. Has such disability existed continuously since before dependent attained age 19? Yes____ No ____

5. Has dependent been confined in a hospital as a result of this disability? Yes_____ No _____
If yes, give name and address of hospital: ____

Date admitted: _______________________________________ Date released: ___________________________________

6. Current treatment:
A. Medication – i.e. dosage, frequency____
B. Care plan ____
C. Compliance with prescribed treatment Good_____________ Fair _____________ Poor____________
D. Currently controlled with medical management? Yes ____ No ____ (if no, why not______________________________
____
E. Goals/Expected Outcome ____

7. Prognosis:
Is dependent totally disabled Yes________ No________
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 the patient recover sufficiently to be capable of self support?_______________________________________
____
If no, please explain: ____
8. Additional remarks: ____
____

Signature: ____ Date: ___________________________