BlueCross BlueShield
of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association.

P.O. Box 805107
Chicago, IL 60680-4112

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 ☐ Single ☐ Married ☐ Widowed ☐ Divorced
3c. Dependent's Relationship to Employee	3d. Dependent's Sex ☐ Male ☐ 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 19? (age 21 if Management) ☐ 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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Disabled Dependent Physician Certification

To: Attending Physician

Claim Number:
Patient Name:
Insured Number:
Service Date:
Provider Name:

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

1. Is dependent now incapable of self-support because of disability? ☐ Yes ☐ No

2. From what age has such disability existed continuously? ☐ From Birth, or ☐ From age _____

3. Nature of disability (please give as much detail as possible, otherwise, it may be necessary to contact you for more specific data). Use reverse side if necessary.

_____

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4. Prognosis: _____

_____

_____ _____ _____ _____
Name of Physician (Print or Type) Degree Physician's Signature Date

_____
Address of Physician (Print or Type)