Excellus

P.O. Box 22999, Rochester, NY 14692
A nonprofit independent licensee of the BlueCross BlueShield Association

Disabled Dependent Form

All Questions Must Be Answered

DO NOT USE – FOR INTERNAL PURPOSES ONLY

HIOS ID#_____
EC_____

✓CHECK DESIRED ACTION
☐ Name Change
☐ New Address

Please complete this application for Disable Dependent membership
Mail form to: Excellus BlueCross BlueShield P.O. Box 22999, Rochester, NY 14692

SUBSCRIBER INFORMATION – MUST BE COMPLETED

Social Security # ☐☐☐-☐☐-☐☐☐☐ Daytime Phone Number ☐☐☐-☐☐☐-☐☐☐☐

Last Name First Name M.I.

Street

City State Zip

I REQUEST CONTINUATION OF COVERAGE FOR THE DEPENDENT NAMED BELOW WHO IS TOTALLY DISABLED

Dependent's Last Name First Name M.I.

Mailing Address Apt or Suite

City State Zip

Date of Birth Social Security Number ☐☐☐-☐☐-☐☐☐☐

Relation to Subscriber

Is dependent married ☐ Yes ☐ No Previously married? ☐ Yes ☐ No

Does Dependent have a contract? If yes, ID#:

Does Dependent have personal income from any source? ☐ Yes ☐ No

Is Dependent claimed on Subscriber's income tax? ☐ Yes ☐ No

To what extent is dependent self-supporting?

Is Dependent a full time student? ☐ No ☐ Yes

If yes, please indicate: Name of School:

Medicare Number (if applicable) Part A Effective Date Part B Effective Date

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Subscriber Signature _____ **Date**_____

TO BE COMPLETED BY DEPENDENT'S ATTENDING PHYSICIAN (M.D. or D.O.)

1. **Diagnosis (Please use standard nomenclature):** _____
_____

2. **If physically disabled, describe physical impairments:** _____
_____

3. **If mental illness*, describe limitations:** _____
_____

4. **If 2 or 3, describe treatment and rehabilitation currently being administered to dependent:** _____
_____

5. **If mental retardation*, describe severity of condition:** _____
_____ **Mental Age:** _____ **I.Q.:** _____

Describe capabilities and limitations of dependent: _____
_____

***PLEASE ATTACH A COPY OF DEPENDENTS LAST PSYCHOLOGICAL EVALUATION, WAIS AND/OR MMPI REPORT.**
YOU MUST COMPLETE THIS AREA IN FULL FOR THE DEPENDENT:

✓CHECK ALL THAT APPLY:

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Feed Self	❑	❑	Dress Self	❑	❑	Bathe Self	❑	❑	Toilet Self
❑	❑	Read	❑	❑	Write	❑	❑	Speak	❑	❑	Handle Money
❑	❑	Drive Vehicle	❑	❑	Ambulate Independently	❑	❑	Transfer Self From Bed to Chair	❑	❑	Use Public Transportation

6. **To your knowledge, length of time this disability has existed:** _____

7. **Probable future course and duration:** _____

8. **Is dependent institutionalized?** ☐ Yes ☐ No If yes, give name of institution _____

9. In your professional opinion, can this patient engage in self-supporting employment? ❑ Yes ❑ No
Please elaborate the reason for your answer: _____
_____

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Physician Signature _____ **Date**_____

Name of Physician (please print) _____ **Phone Number:** _____

Physician's Address _____

Office Use Only

❑ **Not Approved - Reason:** _____

❑ **Approved Effective date** _____ **Processed by** _____ **Date** _____

If you have any questions, please contact your Group Administrator/Representative.
Or, visit us at: www.excellusbcbs.com