165 Court St. Rochester, NY 14647
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: P.O. Box **21146, Eagan, MN 55121**

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: ______________________________

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.

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

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services and are a Child Health Plus or Managed Medicaid member, please call 1-800-650-4359. If you are an Essential Plan member, please call 1-877-626-9298. All others please call 1-800-499-1275.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 1-315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意：如果您说中文，我们可为您提供免费的语言协助。 请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlòp la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

םאזקרעמפיוא: ביוא ריא טדער שידיא, זיא עטסיזמוא ךארפש ףליה וואליעבלע ראפ ךייא עטיב
טרירעפער םוצ ביילגייעלטגןדאקומעט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপদন বা◌া◌ংলা ভাষায় কথা বললন তাহলল আপনার জনয সহায়তা উপলভয রলয়লে। আমালির সলে যযাগালযাগ করার জনয অনুগ্রহ কলর সাংযুক্ত নদথ পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

الوثيقة إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة
المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے
طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra
se si të na kontaktoni.

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