

DISABLED DEPENDENT CERTIFICATION

PLEASE READ CAREFULLY

The "Disabled Dependent Certification" form is used to determine if your adult dependent child meets the plan's eligibility requirements for continued coverage after the age limit is reached.

IMPORTANT NOTE

The inability to find employment or a reduction in work force is, of themselves, NOT evidence of eligibility for continuation of coverage.

INSTRUCTIONS

You or your physician may submit the information requested in this "Disabled Dependent Certification" form. Please complete all required sections and sign the attestation statement at the end.

Step 1: Complete all applicable sections of the Disabled Dependent Certification attached form.

Step 2: Subscriber must complete and sign the applicable fields.

Step 3: Licensed physician must complete and sign the applicable fields. (where applicable)

Step 4: Include one of the following information:

- Copy of the Social Security Disability Insurance* (SSDI) Award Letter (where applicable)
- Copy of the active Court Order (where applicable) example: Legal Guardianship
 - *If copy of SSDI OR Court Order are not available: the Physician's attestation must be completed, and signature required*
- Physician Attestation (where applicable)
 - If child has only SSI** and *not* SSDI*, the child's physician will need to complete section 3; the Physician's Statement.

Step 5: Send to:

Premera
Membership & Billing, MS 137
PO Box 91059
Seattle, WA 98111-9159

If you have any questions regarding the attached form please contact Customer Service at the number located on the back of your ID card.

CONDITIONS OF ELIGIBILITY

Under the provisions of the Contract coverage, a dependent who is mentally or physically disabled may continue coverage to any age provided the dependent is:

1. Dependent became disabled before reaching the limiting age (over the age of 25).
2. Dependent must be incapacitated or incapable of self-sustaining employment.
3. Dependent must be mentally or physically disabled prior to attainment of the age where coverage would otherwise be terminated.

Social Security Disability Insurance is the Federal Insurance Program Supplemental Security Income (SSI) program pays benefits to disabled adults and children who have limited income and resources.

ALL SECTIONS MUST BE COMPLETED PER INSTRUCTIONS (review carefully)

SECTION 1: SUBSCRIBER INFORMATION					
Full name of Subscriber: (last, first, middle)		Subscriber ID#:		Group #:	
Street Address:		City:	State:	Zip code: Telephone No:	
SECTION 2: DEPENDENT INFORMATION					
Full Name of disabled dependent: (last, first, middle)		Date of birth:		Relationship to Subscriber:	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single		Address: (if different than subscriber)			
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Nature of disability:		Date of disability:		
Does dependent currently have other/additional health insurance? (example: Medicare) <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide responses in the fields below.					
Other/Additional Health Insurance Name:		Other Health Insurance ID Number:		Customer Service Number:	
Is the Other Health Insurance company <i>Primary</i> coverage for the dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No					
SOCIAL SECURITY DISABILITY OR LEGAL GUARDIANSHIP SUPPORTING DOCUMENTS					
<p>Has the dependent been declared disabled by the Social Security Administration?</p> <p><input type="checkbox"/> If Yes, (attach SSDI* and SSI** document)</p> <p><input type="checkbox"/> If No, provide subscriber signature below and then continue to section 3</p> <p>If yes, complete the following:</p> <ul style="list-style-type: none"> Copy of the SSDI* Award letter Most recent monthly SSI** statement <p style="text-align: center;">and/or</p> <ul style="list-style-type: none"> Applicable court order Sign on the Subscriber signature line and STOP <p>If no, provide subscriber signature and then continue to section 3.</p> <p>Subscriber Signature:</p> <p>_____</p>		OR	<p>Has the dependent been placed in Legal Guardianship by a court order?</p> <p><input type="checkbox"/> If Yes, (attach active court order)</p> <p><input type="checkbox"/> If No, provide subscriber signature below and then continue to section 3</p> <p>If yes, complete the following:</p> <ul style="list-style-type: none"> Attach the copy of the active Legal Guardianship court order Sign on the Subscriber signature line and STOP <p>If no, provide subscriber signature below and then continue to section 3.</p> <p>Subscriber Signature:</p> <p>_____</p>		

** The attending physician's statements regarding disability status are necessary and important for Premera; however, Premera is not bound by the physician's conclusion.

SUBSCRIBER SIGNATURE – must be signed for the form to be valid

Please note: it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I certify/attest that <Dependent's Name> meets the following criteria:

1. The dependent became disabled before reaching the limiting age; and
2. Is incapable of self-sustaining employment due to disability; and
3. The dependent relies primarily upon Subscriber (and/or spouse) for support and maintenance.

Subscriber's Signature _____

Date of Signature _____

(My signature attests that the above statements are true and if requested I can provide further substantiating documentation.)

SECTION 3: PHYSICIAN'S INFORMATION – the following must be completed, signed and certified by a physician

IMPORTANT NOTE

The inability to find employment or a reduction in work force is, of themselves, NOT evidence of eligibility for continuation of coverage

ATTENDING PHYSICIAN'S STATEMENT

- It is imperative that we have complete medical proof of your dependent's disability. This should be supplied by the physician(s) who treated your dependent during the entire period of disability.
- The inability to find employment or a reduction in work force is, of themselves, NOT evidence of eligibility for continuation of coverage.

Provider Name: 	Provider Mailing Address: 	Provider Contact Phone: Fax Number:
Date of Patient's last exam: <small>(The application date and date of the last exam must be within the past year)</small>	Disability is Complete 100% <input type="checkbox"/> Yes <input type="checkbox"/> No	Disability is: Partial ____%
Is this disability temporary or permanent? <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent		If temporary, estimated duration:

Diagnosis causing disability: (provide ICD-10 and standard nomenclature of condition)

Will dependent/patient be capable of self-support Yes No. If yes, when (date)

Please note: it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signature of Attending Physician (Print / Credentials): _____

Date of Signature: _____

(My signature attests that the above statements are true and if requested I can provide further substantiating documentation.)

** The attending physician's statements regarding disability status are necessary and important for Premera; however, Premera is not bound by the physician's conclusion.

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera 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: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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 Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល

គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471 (TTY:711) まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711)።

XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajjila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711). *ملحوظة:* إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດອຸບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີສ່ວນໃຫ້ທ່ານ. ໂທ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.