

## Application for Extension of Coverage Disabled Dependent Child

### APPLICATION COMPLETION CHECKLIST

#### Application

- Be sure to complete all questions in full (incomplete applications cause unnecessary delays or declines)
- Sign and date the application where appropriate
- If more space is needed for any answers, attach a separate piece of paper
- Treating physician must complete Section II
- Make a copy for your records

#### Submit Application

Return application via one of the following options:

- Mail to:  
Blue Cross and Blue Shield of Nebraska  
Individual Underwriting Department  
PO Box 3248  
Omaha, NE 68180-001
- Fax: 402-548-4685
- Log in to your myNebraskaBlue account and submit through the message center

For additional help, or if you have any questions, please call Member Services at the number on the back of your ID card.



PO Box 3248  
Omaha, NE 68180-001  
NebraskaBlue.com

# Application for Extension of Coverage Disabled Dependent Child

Use this form to request an extension of coverage for a disabled dependent child who is currently covered by Blue Cross and Blue Shield of Nebraska (BCBSNE) but has reached the maximum dependent age limit.

Under certain circumstances, a mentally or physically disabled dependent child who is a Covered Person is entitled to extended coverage past the date the child's coverage would otherwise end.

## Section I Dependent Child Eligibility

*(To be completed by the subscriber)*

Subscriber Name: \_\_\_\_\_

Subscriber Address: \_\_\_\_\_

Subscriber Member ID Number: \_\_\_\_\_

Dependent Child Legal Name: \_\_\_\_\_

Dependent Child Date of Birth (MM/DD/YYYY): \_\_\_\_\_

Is the dependent child married?  Yes  No

Do you claim the dependent child on your Federal Income Tax?  Yes  No

Do you provide over half of the dependent child's financial support?  Yes  No

Does the dependent child reside with you?  Yes  No

Is the dependent child employed for wages?  Yes  No

If yes, please provide the name and address of current employer: \_\_\_\_\_

Average weekly earnings: \_\_\_\_\_

Is the dependent child eligible for Medicaid?  Yes  No

Is the dependent child eligible for Medicare for the Disabled?  Yes  No

Is the dependent child enrolled in another health care plan?  Yes  No

If yes, please provide the name of insurance company: \_\_\_\_\_

## Acknowledgments and Authorizations

I understand and agree to the following:

1. The above-named disabled dependent child is incapable of self-sustaining employment by reason of mental or physical handicap.
2. The above-named disabled dependent child lives with me; their care is provided by me (Subscriber); and I provide over half of their support and maintenance.
3. The statements and responses I've provided are true and complete to the best of my knowledge and acknowledge that BCBSNE has relied on these answers in determining whether to accept this application.
4. Any intentional misrepresentation in this application may cause the coverage to be void.
5. My signature authorizes any health care provider to release protected health information (PHI) to BCBSNE for the purpose of determining eligibility for continuation of coverage.
6. BCBSNE reserves the right to request additional documentation and reconsider the coverage application based on new information.

Subscriber's Signature: \_\_\_\_\_ Date (MM/DD/YYYY): \_\_\_\_\_

**Section II Certification of Treating Physician**

*(To be completed by treating physician)*

Treating physician:

Please complete Section II of this form and mail it to the address above.

1. Date dependent became disabled (MM/DD/YYYY): \_\_\_\_\_

2. Diagnosis(es) causing disabled status: \_\_\_\_\_

Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_

3. (a) Is the dependent presently capable of self-sustaining employment?  Yes  No

(b) If NO, in your opinion, will the dependent ever be capable?  Yes  No

(c) If your answer to 3b is YES, when, in your opinion will the dependent be capable of self-sustaining employment? \_\_\_\_\_

4. (a) Does the dependent have a physical or intellectual disability or combination of both?  Yes  No

(b) Did the condition manifest before the person attained age twenty-six (26)?  Yes  No

5. Describe past and present treatment including dates.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Describe anticipated future treatment.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Treating Physician Printed Name: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician Phone Number: \_\_\_\_\_

Treating Physician's Signature: \_\_\_\_\_

Date Signed (MM/DD/YYYY): \_\_\_\_\_