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

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.com 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.

BlueCross BlueShield Nebraska

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 are 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): _____