BlueCross BlueShield of Nebraska

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Extension of Coverage Request

For a mentally or physically handicapped Dependent.

Under certain conditions, a mentally or physically disabled dependent child who was a Covered Person is entitled to extended coverage past the date the child's coverage would otherwise end. Full and correct completion of this form will assist Blue Cross and Blue Shield of Nebraska in determining whether or not a child is so entitled.

Section I (To be completed by Contract Holder)

Name of Member: _____

Address of Member: _____

Identification Number or Social Security Number: _____

Name of Dependent: _____

Dependent's Date of Birth (Mo., Day, Year): _____

Dependent's Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Yes	No	
☐	☐	Was Dependent ever institutionalized?

If Yes, give name and address of institution(s) and period confined (from - to)

☐	☐	Is the Dependent eligible for Medicare for the disabled?
☐	☐	Is the Dependent eligible for Medicaid?
☐	☐	Is the Dependent eligible for or enrolled in another health care plan? If Yes, name of insurance company:

Is this coverage being terminated? ☐ Yes ☐ No Reason:

☐	☐	Do you provide financial support for this dependent?
☐	☐	Has the Dependent been a full-time student?

Type of facility: ☐ school for the handicapped ☐ regular school

Last date of attendance: _____ Number of credit hours: _____

If applicable, date of expected return to school as full-time student: _____ (Month Day Year)

If applicable, date of expected return to school part-time: _____ (Month Day Year)

☐	☐	Is the Dependent employed for wages?

If Yes, give name and address of current employer:

Average weekly earnings: _____

Signature of Parent _____ Date Signed _____

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(Section II to be completed by Physician on reverse side **)**

Section II (To be completed by Physician)

Diagnosis of condition causing disabled status:

Primary: Date of onset: _____

Secondary: Date of onset: _____

- Complete Part A if either (a) the disability began before age 19, or (b) the disability began after age 19 but it is expected to be permanent or long term (more than 4 semesters).
- Complete Part B if disability began after age 19 and is expected to be short term (4 semesters or less).

Part A

1. (a) Is Dependent presently capable of self-sustaining employment? . . . . . ☐ Yes ☐ No
   (b) If NO, in your opinion, will the Dependent ever be capable? . . . . . ☐ Yes ☐ No
   If 1(b) is YES, when, in your opinion, will Dependent be capable of self-sustaining employment? _____
2. (a) Is Dependent mentally competent to handle his/her affairs? . . . . . ☐ Yes ☐ No
   (b) Is Dependent physically and mentally capable of attending to his/her needs of independent living? . . . . . ☐ Yes ☐ No
   If 2(a) or 2(b) is answered NO, please check the following reasons which apply:

   ☐ The Dependent is not capable of performing one or more activities of daily living such as bathing, meal preparation, dressing, or taking medications.

   ☐ The Dependent is not able to comprehend and express language.

   ☐ The Dependent is not mentally capable of the significant learning or the vocational training needed to be self-supporting.

   ☐ The Dependent is not physically capable of self-mobility.

   ☐ Other
   Please explain: _____

Part B

1. Describe past and present treatment. Include dates.

2. Describe anticipated future treatment.

3. Give dates of disability from full-time school attendance (From - To)

4. If date of return to school unknown, please provide expected date of return.

   Part Time Status, if Applicable _____ (Month Day Year) Full Time Status _____ (Month Day Year)

Signature of attending M.D.: _____ Date signed _____

Printed Name and Address of Doctor:

Attending Physician: Please complete the physician's section of the form and mail to:

Blue Cross and Blue Shield of Nebraska • P.O. Box 3248 • Omaha, NE 68180-0001

For Blue Cross and Blue Shield of Nebraska Use Only

☐ Approved From _____ to _____

Signature _____

☐ Rejected Date: _____