PREMERA | BLUE CROSS

Disabled Dependent Certification

PO Box 327, MS 737
Seattle, WA 98111-0327

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.

Please keep in mind

- 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:
  - Dependent became disabled before reaching the limiting age (over the age of 25).
  - Dependent must be incapacitated or incapable of self-sustaining employment.
  - Dependent must be mentally or physically disabled prior to attainment of the age where coverage would otherwise be terminated.
- The inability to find employment or a reduction in work force is, of themselves, NOT evidence of eligibility for continuation of coverage.
- You or your physician may submit the information requested in this Disabled Dependent Certification form.
- Subscribers must complete all required sections and sign the attestation statement at the end.
- Licensed physician, where applicable, must complete and sign the applicable fields.
- Include one of the following pieces of documentation with your completed and signed form.
  - Copy of the Social Security Disability Insurance[1] (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[2] and *not* SSDI, the child's physician will need to complete section 3; the Physician's Statement.

Next steps

To help process your form, please make sure it's fully completed, signed, and returned with all required information and documents (as applicable).

Submit your application by mailing or emailing

Mail to:
Premera Blue Cross
Membership & Billing
PO Box 327, MS 737
Seattle, WA 98111-0327

Fax to:
888-251-7319

Questions?

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

[1] 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.
[2] The attending physician's statements regarding disability status are necessary and important for Premera; however, Premera is not bound by the physician's conclusion.

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Instructions

- All fields are required.

Subscriber completes this section. All fields are required.

Section 1: Subscriber information				
Full name of subscriber (last, first, middle)		Subscriber ID#		Group ID
Street address	City	State	Zip code	Phone number (10 digit)

Section 2: Dependent information		
Full name of disabled dependent (last, first, middle)	Date of birth	Relationship to subscriber

Marital status – select one ❍ Married ❍ Single	Address: (if different from subscriber)	
Gender – select one ❍ Male ❍ Female	Nature of disability	Date of disability

Does dependent currently have other/additional health insurance? Select one. (Example: Medicare)
❍ Yes. Provide responses in the fields below for Other/additional health insurance.
❍ No

Other/additional health insurance	Name	ID number	Customer service phone number (10 digit)
	Is this the primary coverage for the dependent? Select one. ❍ Yes ❍ No		

What is the purpose of this certification? Select all that apply.
☐ Medical benefits ☐ Medical travel benefits

Section 3: Social security disability or legal guardianship supporting documents

Select only one statement and follow the instructions.

❍ Yes, the dependent been declared disabled by the Social Security Administration.
Complete section 3A.

❍ Yes, the dependent been placed in Legal Guardianship by a court order.
Complete section 3B.

❍ No, neither of these statements is true. Sign here and skip to sections 4 and 5.
Subscriber signature: _____

Section 3A: Dependent is declared disabled by the Social Security Administration

1. Attach copies of SSDI* and SSI documents.
2. Attach a copy of the SSDI* Award letter.
3. Attach a copy of the most recent monthly SSI statement and/or applicable court order
4. Sign here on the Subscriber signature line. Once you sign, you have completed this form. STOP. Return it to the address in the cover letter for this form.

Subscriber signature: _____

Section 3B: Dependent has been placed in Legal Guardianship by a court order.

1. Attach a copy of the active Legal Guardianship court order.
2. Attach a copy of the SSDI* Award letter.
3. Attach a copy of the most recent monthly SSI statement and/or applicable court order
4. Sign here on the Subscriber signature line. Once you sign, you have completed this form. STOP. Return it to the address in the cover letter for this form.

   Subscriber signature: _____

Section 4: 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 attest that dependent named in section 2 of this document

1. Has been declared disabled before reaching the limiting age; and
2. Is incapable of self-sustaining employment due to disability; and
3. Relies primarily upon subscriber (and/or spouse) for support and maintenance.

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

Subscriber's signature _____ Date signed _____

Physician completes this section. All fields are required.

Section 5: Physician's information - The following must be completed, signed, and attested by a physician.

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

Provider Information	Name (last, first, middle)	Address	
	Contact name	Phone number (10 digit)	Fax number (10 digit)

Date of patient's last exam (The application date and date of the last exam must be within the past year) _____	Identify level of disability – select one ❍ Disability is 100% complete ❍ Disability is partial: _____%	
	Is this disability temporary or permanent? ❍ Temporary ❍ Permanent	If temporary, estimated duration:

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

Will dependent/patient be capable of self-support? Select one.
❍ Yes. If yes, date: _____ ❍ No

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.

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

Attending physician's signature _____ Date signed _____

Print physician's name and credentials _____

Notice of availability and nondiscrimination **800-722-1471 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
મુફત ભાષા સહાયિતા સેવાવાં અને ઉચિત સહાયિક ચીજાં અને સેવાવાં વાસતે કાલ કરો।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໃຫ້ເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທ່ເໝາະສົມແບບບ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 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, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

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037397 (07-05-2024)

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