Application for Intellectual or Physical Dependent Disability

Instructions for completing form:

- **Subscriber** - Complete Subscriber and Dependent sections
- **Physician** - Complete Physician Statement section
- Make sure all forms are signed by Subscriber and Physician

Medical Chart notes for this applicant for past 2 years are required to be submitted. If records are not submitted with this application form, the application will be denied.

Subscriber Information		
Unique Member Identifier Number		
Subscriber First Name	Subscriber Last Name	
Address		
City	State	Zip Code
Preferred Phone Number	Phone Number Type: ☐ Mobile ☐ Home ☐ Work	
Relationship to the Dependent (e.g. mother, father, guardian, etc)		

Dependent Information - To be Completed by the Subscriber	
Dependent First Name	Dependent Last Name
Dependent's Social Security Number	Dependent's Date of Birth

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Subscriber's Statement - To be Completed by the Subscriber

1. Is the Dependent claimed on the Subscriber's federal tax income return? ☐ Yes ☐ No

   Note: If No, the Dependent is not eligible for coverage.

   If Yes, how many years have they been claimed on the Subscriber's federal income tax return?

   Please provide copies of federal income tax returns for the last two years. If you don't have two years, please explain why.

2. Is the Dependent 26 years or older? ☐ Yes ☐ No

   If Yes, has the Dependent been continuously covered as a Dependent on a parent's insurance plan since aging off that plan?

   ☐ Yes ☐ No

   ***Please provide Certificate of Coverage for the lines of coverage (Health/Dental/Vision) applying for.

   Note: If the Dependent hasn't been continuously covered under a parent's insurance plan, the Dependent is not eligible for coverage.

3. Is the Dependent married? ☐ Yes ☐ No

   If Yes, the Dependent is not eligible for coverage.

4. Does the Dependent reside at the home of the Subscriber? ☐ Yes ☐ No

   If No, why? (e.g. divorce decree, group home, residential facility)

   Address of Dependent:

   Address City State Zip Code

5. Is the Dependent capable of ANY employment? ☐ Yes ☐ No

   If yes, is the Dependent employed? ☐ Yes ☐ No

   Where:

   Job Description:

   Number of Hours per Week:

   Method of transportation to and from job (drives car, uses public transportation, uses special van (e.g. "Handiwheels", etc):

6. Does the Dependent have a diagnosis of intellectual disability? ☐ Yes ☐ No

Subscriber's Statement - To be Completed by the Subscriber

7. Does the Dependent have a diagnosis of physical disability? ☐ Yes ☐ No

8. Does the Dependent have a diagnosis of any seizure disorder? ☐ Yes ☐ No
   If Yes, when was the last seizure?

   Medication, dose and frequency:

   Number of seizures per day:

9. Does the Dependent attend school? ☐ Yes ☐ No
   If Yes, where?

   What grade level?

   Check the following that apply:
   - ☐ Attends a mainstream class experience
   - ☐ Attends a special education class experience
   - ☐ Receives training and/or education specific to the disability

10. Is the Dependent blind/or deaf? ☐ Yes - Blind ☐ Yes - Deaf ☐ No
    If Yes, does/did the Dependent attend special education for the disability? ☐ Yes ☐ No

11. Was the Dependent born with the disability? ☐ Yes ☐ No

12. Was the disability acquired? ☐ Yes ☐ No
    If Yes,
    Where:

    When:

    How:

Subscriber's Statement - To be Completed by the Subscriber

13. What is the Dependent's level of activity for Activities of Daily Living (ADL's)?

- ☐ Needs complete assistance in feeding, dressing, etc.
- ☐ Needs partial assistance in feeding, dressing, etc.
- ☐ Needs mental cueing to do activity
- ☐ Needs assistance for mobility, does most ADL's independently (i.e. needs assist to wheelchair, car, bed)
- ☐ Independent for activities of daily living

14. What is the expected date of improvement in condition or recovery?

- ☐ Disability is considered permanent
- ☐ Disability is of a nature that Dependent status MIGHT change after sufficient education and training
- ☐ Disability is of a nature that Dependent status WILL change after sufficient education and training
- ☐ Unknown

I hereby authorize Doctor _____ to complete the Physician Statement portion of this form and forward it to:

- Blue Cross Blue Shield of North Dakota
  4510 13th Avenue South
  Fargo, North Dakota 58121

Physician Statement – To Be Completed by the Attending Physician

Medical Chart notes for this applicant for past 2 years are required to be submitted. If records are not submitted with this application form, the application will be denied.

Records from the Physician filling out the form. Request documentation from the treating health care provider from the last two years to support the diagnoses on the application and include details regarding members abilities and level of function.

This is to certify that _____
has the specific diagnosis(es) (ICD-10)

☐ This Dependent is receiving the following medications related to the diagnosis(es):

Physician Statement – To Be Completed by the Attending Physician

☐ The disability is of a permanent nature (i.e. anacephalic, quadriplegia, intellectual disability) such that the Dependent is incapable of self-support because of the intellectual disability or physical disability. This disability prevents him or her from engaging in ANY occupation or employment. (Please provide supporting information being as specific as possible.)

☐ The disability is of a partial nature (i.e. blind, deaf, mild intellectual disability, etc.) (Please provide supporting information being as specific as possible.)

☐ There is potential for independent living with appropriate education at sometime in the future. (Please provide supporting information being as specific as possible.)

Signatures

Subscriber Signature		Date (mm/dd/yyyy)
Subscriber Address		
City	State	Zip Code
Physician Signature		Date (mm/dd/yyyy)