



Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association

Please return the completed form.

By Mail: PO Box 1106
Lewiston, ID 83501
By Fax: 1 (208) 798-2047

OFFICE USE ONLY	
<input type="checkbox"/>	Never Recertify
<input type="checkbox"/>	Recertify in two years

Affidavit of Qualifying Incapacitated Dependent Eligibility for Individual Coverage

SECTION 1 - STATEMENT OF DEPENDENT'S ELIGIBILITY (to be completed by the Policyholder)

Policyholder's Name		ID Number	
Policyholder's Address		City	State ZIP Code
Dependent's Name		Dependent's Birthdate	
Dependent's Relationship to Policyholder		Dependent's Marital Status	
Dependent's Address (if not residing with policyholder)		City	State ZIP Code
Please explain why dependent does not reside with policyholder.			
Is dependent currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Employment Began _____	
Position Held _____		Average Hours Worked Per Week _____	
Dependent's Current Employer's Name			
Current Employer's Address		City	State ZIP Code
Was dependent previously employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dates of Employment _____ to _____	
Position Held _____		Average Hours Worked Per Week _____	
Dependent's Previous Employer's Name			
Dependent's Previous Employer's Address		City	State ZIP Code
Does dependent have other health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the name of the carrier, policyholder's name, policy number and carrier's phone number:			
Is the dependent eligible for or have Medicare coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the type of coverage, effective date and the Medicare Number (please include the alpha prefix):			
Has the dependent been declared disabled by the Social Security Administration? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the date of acceptance? _____ (please attach a copy of the SSI acceptance letter)			
What is the dependent's estimated gross monthly income from all sources \$ _____		What is the percentage of dependent's financial support supplied by policyholder _____ %	
I certify that _____, meets the following criteria: Name of incapacitated dependent (please print)			
<ol style="list-style-type: none"> Has been continuously covered by health insurance as my dependent with no break in coverage of more than 63 days; Is incapable of self-sustaining employment due to incapacitation related to developmental disability, medical disability, and/or mental disorder; and Is significantly dependent upon policyholder (and/or policyholder's spouse) for support and maintenance. 			
Signature of Policyholder		Date	



SECTION 2 - STATEMENT OF INCAPACITATION (to be completed by the dependent's attending physician*)

Provider's Name			Provider's Telephone Number
Provider's Address	City	State	ZIP Code
Patient's Name			Patient's Birthdate

Date patient was last examined by attending physician	Nature of condition causing incapacity: <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Medical Disability <input type="checkbox"/> Mental Disorder <input type="checkbox"/> Other (please explain) _____
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Incapacitation is: <input type="checkbox"/> Complete <input type="checkbox"/> Partial _____ % incapacitated	Incapacitation is: <input type="checkbox"/> Temporary (estimated duration is) _____ <input type="checkbox"/> Permanent At what age did patient become incapacitated? _____
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Diagnosis of Condition Causing Incapacity: (Give as much detail as possible. Please give dates of surgery, forward laboratory data and results of special tests, such as x-rays, EKG's, EEG's, etc. If mental retardation is present, give severity of retardation and IQ test score. Attach additional pages as necessary.)

Diagnosis _____

Comments to Support Incapacity _____

Is patient or will patient be capable of self-support? Yes No

If yes, please explain _____

Is patient able to perform full or part-time work of any kind? Yes No

Has patient previously been able to perform full or part-time work of any kind? Yes No

Does patient have a job? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Do you know what duties the patient's job requires? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
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_____	_____
Attending Physician's Name (please print)	Attending Physician's Credentials
_____	_____
Signature of Attending Physician	Date

*The attending physician's statements regarding incapacitation are necessary and important for Regence's incapacitation determination; however Regence is not bound by the physician's conclusion.

