Regence

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

Please return the completed form.
By Mail: PO Box 30270, MS:23
Salt Lake City, UT 84130-0270
By Fax: 1 (866) 797-1786

OFFICE USE ONLY
☐ Never Recertify
☐ 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? ☐ Yes ☐ No

Position Held ______

Date Employment Began ______

Average Hours Worked Per Week ______

Dependent's Current Employer's Name

Current Employer's Address	City	State	ZIP Code

Was dependent previously employed? ☐ Yes ☐ No

Position Held ______

Dates of Employment ______ to ______

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? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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)

1) Has been continuously covered by health insurance as my dependent with no break in coverage of more than 63 days;
2) Is incapable of self-sustaining employment due to incapacitation related to developmental disability, medical disability, and/or mental disorder; and
3) 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	Provider's Tax ID Number
Patient's Name				Patient's Birthdate

Date patient was last examined by attending physician

Nature of condition causing incapacity:

☐ Developmental Disability ☐ Medical Disability

☐ Mental Disorder ☐ Other (please explain) ____________

Incapacitation is:

☐ Complete

☐ Partial ________ % incapacitated

Incapacitation is:

☐ Temporary (estimated duration is) ____________ ☐ Permanent

At what age did patient become incapacitated? ____________

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? ☐ Yes ☐ No ☐ Unknown

Do you know what duties the patient's job requires? ☐ Yes ☐ No
If yes, please explain:

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.**