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DISABLED DEPENDENT CERTIFICATION

PLEASE READ CAREFULLY

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.

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

INSTRUCTIONS

You or your physician may submit the information requested in this "Disabled Dependent Certification" form. Please complete all required sections and sign the attestation statement at the end.

Step 1: Complete all applicable sections of the Disabled Dependent Certification attached form.

Step 2: Subscriber must complete and sign the applicable fields.

Step 3: Licensed physician must complete and sign the applicable fields. (where applicable)

Step 4: Include ***one*** of the following information:

- Copy of the Social Security Disability Insurance* (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** and *not* SSDI*, the child's physician will need to complete section 3; the Physician's Statement.

Step 5: Send to:

Premera
Membership & Billing
PO Box 327 MS 737
Seattle, WA 98111-0327

Or Fax: 888-251-7319

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

CONDITIONS OF ELIGIBILITY
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:

1. Dependent became disabled before reaching the limiting age (over the age of 25).
2. Dependent must be incapacitated or incapable of self-sustaining employment.
3. Dependent must be mentally or physically disabled prior to attainment of the age where coverage would otherwise be terminated.

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.

** 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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ALL SECTIONS MUST BE COMPLETED PER INSTRUCTIONS (review carefully)

SECTION 1: SUBSCRIBER INFORMATION

Full name of Subscriber: (last, first, middle)	Subscriber ID#:		Group #:	
Street Address:	City:	State:	Zip code:	Telephone No:

SECTION 2: DEPENDENT INFORMATION

Full Name of disabled dependent: (last, first, middle)	Date of birth:	Relationship to Subscriber:
Marital Status: ☐ Married ☐ Single	Address: (if different than subscriber)	
Sex: ☐ Male ☐ Female	Nature of disability:	Date of disability:

Does dependent currently have other/additional health insurance? (example: Medicare) ☐ Yes ☐ No

If Yes, provide responses in the fields below.

Other/Additional Health Insurance Name:	Other Health Insurance ID Number:	Customer Service Number:

Is the Other Health Insurance company *Primary* coverage for the dependent? ☐ Yes ☐ No

SOCIAL SECURITY DISABILITY OR LEGAL GUARDIANSHIP SUPPORTING DOCUMENTS

Has the dependent been declared disabled by the Social Security Administration?

☐ If **Yes**, (attach SSDI *and SSI** document)
☐ If **No**, provide subscriber signature below and then continue to section 3

If **yes**, complete the following:

- Copy of the SSDI* Award letter
- Most recent monthly SSI** statement
  and/or
- Applicable court order
- Sign on the Subscriber signature line and **STOP**

If **no**, provide subscriber signature and then continue to section 3.

Subscriber Signature:

_____

OR

Has the dependent been placed in Legal Guardianship by a court order?

☐ If **Yes,** (attach active court order)
☐ If **No**, provide subscriber signature below and then continue to section 3

If **yes**, complete the following:

- Attach the copy of the active Legal Guardianship court order
- Sign on the Subscriber signature line and **STOP**

If **no**, provide subscriber signature below and then continue to section 3.

Subscriber Signature:

_____

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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 certify/attest that <Dependent's Name> meets the following criteria:

1. The dependent became disabled before reaching the limiting age; and
2. Is incapable of self-sustaining employment due to disability; and
3. The dependent relies primarily upon Subscriber (and/or spouse) for support and maintenance.

Subscriber's Signature _____

Date of Signature _____

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

SECTION 3: PHYSICIAN'S INFORMATION – the following must be completed, signed and certified by a physician

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

Provider Name:	Provider Mailing Address:	Provider Contact Phone: Fax Number:
Date of Patient's last exam: (The application date and date of the last exam must be Must be within the past year)	Disability is Complete 100% ☐ Yes ☐ No	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 ☐ Yes ☐ No. If yes, when (date)		

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.

Signature of Attending Physician (Print / Credentials): _____

Date of Signature: _____

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

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

Notice of availability and nondiscrimination **800-508-4722 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Hu thov kev pab txhais lus pub dawb thiab lwm yam khoom pab dawb thiab kev pab cuam ua tsim nyog.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
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。
Vala‘au mo auaunaga tau fesoasoani mo gagana e leai ni totogi ma fesoasoani fa‘aopo‘opo talafeagai ma auaunaga.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
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。
Tumawag para kadagiti libre a serbisio iti tulong iti pagsasao ken dagiti nakanada nga aid ken serbisio iti komunikasion.
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
ติดต่อขอบริการช่วยเหลือด้านภาษาฟรีพร้อมความช่วยเหลือและบริการอื่น ๆ เพิ่มเติม
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
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.
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 Blue Shield of Alaska (Premera) complies with applicable Federal 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, or sex. 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, or sex, 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.