HANDICAPPED / DISABLED DEPENDENT DETERMINATION

P.O. Box 4445
Atlanta, GA 30302
Fax: 404-842-8040

Contract holder must fill in all fields on the application or it will not be processed.

Full Name of Contract Holder (Last, First, Middle)	Group Number	Contract Number
Mailing Address / City / State / Zip Code		Telephone Number

Full name of handicapped/disabled dependent (Last, First, Middle)	Birthdate	Sex ☐ Male ☐ Female	Social Security No. of Dependent

Marital Status of Dependent ☐ Married ☐ Single	Relationship To Contract Holder	Nature of Disability	Date of Disability

Is dependent listed as Income Tax exemption? ☐ Yes ☐ No	Was or is dependent employed for wages? ☐ Yes ☐ No

Name of Dependent (s) last Employer	Address of Dependent (s) last Employer (Street, City, State, Zip Code)	Average Weekly Earnings

Reason for Termination	Termination Date	Does dependent now have any Hospital/Medical coverage? If "Yes", complete details below. ☐ Yes ☐ No

OTHER INSURANCE POLICIES PROVIDING FOR DISABILITY, SICKNESS OR ACCIDENT BENEFITS FOR THE DEPENDENT

Company Name	Address (Street, City, State, Zip Code)	Policy or Certificate Number

Is dependent eligible for care under Federal, State or Local Law? ☐ Yes ☐ No	If "Yes", give type of care	Address of agency providing care (Street, City, State, Zip Code)
Is dependent currently receiving Social Security benefits? ☐ Yes ☐ No	If "Yes", what was the effective date?	If "No", have benefits been denied? ☐ Yes ☐ No

THE FOLLOWING MUST BE COMPLETED AND CERTIFIED BY A PHYSICIAN

1. The above named dependent is presently incapable of self-sustaining employment by reason of (Check One) ☐ Mental Handicap ☐ Physical Handicap ☐ Total Disability	Is handicap congenital? ☐ Yes ☐ No

2. Diagnosis of condition(s), illness or injury causing status checked in Number 1 above (Describe fully the nature of the disability)	Date of Disability Mo. / Day / Year

Name of Disabling Diagnosis
ICD-9 Code(s)
3. Prognosis and estimated number of months or years

4. Was dependent hospital confined? ☐ Yes ☐ No		Name of hospital, if admitted as an inpatient
Admitted (Mo., Day, Year)	Discharged (Mo., Day, Year)	Address of hospital (Street, City, State, Zip Code)

Admitting Diagnosis	ICD-9 Code

Date dependent became totally and continuously disabled and completely prevented from engaging in any occupation whatsoever for compensation	Mo. / Day / Year

Has dependent been able to engage in any gainful occupation or do any work since the disability began? ☐ Yes ☐ No	Date dependent resumed work or expects to resume work	Mo. / Day / Year

11085 07/05

PHYSICIANS CONSULTED SINCE DISABILITY BEGAN	ADDRESS	DATES CONSULTED	
		FROM	TO

Name of Attending/Admitting Physician	Signature of Physician certifying above information	Date Signed
		/ /

I agree that any coverage which may be issued to the dependent named hereon shall be binding only if all statements in this certification are complete and true, and if approved by the Blue Cross and Blue Shield of Georgia Plan. Furthermore, the Plan may declare ineffective the applicant coverage if any statement is not complete and true.

I, the undersigned, hereby certify that the above statements are each and all complete and true to the best of my information knowledge and belief, and that they are made for the purpose of securing the disability benefits set forth in the disability provision contained in the above described policy or policies. I agree that these statements and the statements of all physicians who attended or treated the insured shall constitute the basis of this claim, and further agree that the furnishing of this form or any other forms supplemental thereto by Blue Cross and Blue Shield of Georgia (the Plan) shall not be considered an admission by it of any liability, nor a waiver of any of its rights or defenses.

The undersigned hereby waives on behalf of himself or of any person who shall be interested in the policies hereinbefore mentioned, all provision of law forbidding or restricting any physician or other person who, at any time, attended or examined the insured form disclosing in the courts or otherwise, any knowledge, information or belief which he thereby acquired, and I hereby specifically authorize all such persons, including hospitals, to freely communicate their knowledge to the Plan, if it requests them to do so.

______________________   ____/____/____   ______________________

SIGNATURE (If signed by anyone other than the insured, explain on reverse side) | DATE | WITNESS

PLEASE READ CAREFULLY
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. **Unmarried, and**
2. **So Incapacitated as to be incapable of self-sustaining employment, and**
3. **Mentally or physically disabled prior to attainment of the age where coverage would otherwise be terminated.**
4. **No lapse of coverage greater than 60 days.**

IMPORTANT POINTS:

Neither a reduction in work capability, nor inability to find employment, are, of themselves, evidence of eligibility for continuation of coverage.

Blue Cross and Blue Shield contract benefits will not be provided when such benefits are available in whole or in part, under the laws of the United States of America or any state or political subdivision thereof.

INSTRUCTIONS

We want to complete the processing of your application at the earliest possible date. In order to avoid delay, please read and follow the instructions printed below.

I. APPLICATION

A. Please answer all questions fully. If you do not have sufficient space, you may attach a separate sheet.

B. If you are self-employed, please attach a separate sheet indicating the present status of your business (i.e. sold, leased, liquidated, etc.)

II. ATTENDING PHYSICIAN'S STATEMENT

A. It is imperative that we have complete medical proof of your dependent's disability. This should be supplied by the physician(s) who treated your dependent during the entire period of disability. If additional space is needed, please attach a separate sheet or complete office records.

B. Please ask your physician to answer **all** questions fully and to give **exact** dates. If any changes and/or corrections are necessary, please be sure that each change is initialed by the physician.