SUBSCRIBER REQUEST FOR COVERAGE FOR AN ADULT DEPENDENT DUE TO DISABILITY

TO BE COMPLETED BY HEALTH BENEFITS SUBSCRIBER
(MUST BE ACCOMPANIED BY MEDICAL CERTIFICATION FORM)

MEMBER INFORMATION:					
NAME OF SUBSCRIBER	STREET ADDRESS CITY STATE ZIP				
SUBSCRIBER ID NUMBER	GROUP NUMBER	GROUP NAME			
NAME OF DEPENDENT	BIRTH DATE MO. DAY YR.	MARITAL STATUS (CHECK ONE):			
			SINGLE		WIDOWED
			MARRIED		DIVORCED
			SEPARATED		OTHER

SECTION ONE:
IS DEPENDENT EMPLOYED FOR WAGES? YES NO
IF YES, PLEASE NAME OF EMPLOYER AND APPROXIMATE NUMBER OF HOURS WORKED PER WEEK:
IS DEPENDENT CONFINED TOAN INSTITUTION OR ATTENDING SCHOOL? YES NO
IF YES, GIVE NAME OF INSTITUTION OR SCHOOL AND DATE OF ADMISSION:
IS YOUR SON OR DAUGHTER CHIEFLY DEPENDENT UPON YOU FOR SUPPORT? YES NO
IS DEPENDENT ENTITLED TO RECEIVE MEDICARE BENEFITS? NO YES, PART A PART B PLEASE CIRCLE ALL THAT APPLY
HOW LONG HAS YOUR DEPENDENT'S DISABILITY EXISTED?

SECTION TWO:

Please continue coverage for my adult dependent child under my Blue Cross and Blue Shield of Vermont membership.

I understand that my dependent may be covered under my membership only so long as:

- He or she is incapable of self-support because of a physical or mental disability that existed prior to age 26, and
- I furnish more than half of this dependent's support.

I also understand that:

- It is my responsibility to notify Blue Cross and Blue Shield of Vermont of any change in the status of my dependent's disability, and that
- Blue Cross and Blue Shield of Vermont shall have the right to require recertification as to the eligibility for continuation of coverage as a disabled dependent.

The information I've supplied above is, to the best of my knowledge, correct.

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Subscriber's Signature Date

MEDICAL CERTIFICATION FOR COVERAGE FOR AN ADULT DEPENDENT DUE TO DISABILITY

TO BE COMPLETED BY THE ADULT DEPENDENT'S PRIMARY HEALTH CARE PROVIDER OR ATTENDING SPECIALIST

MEMBER INFORMATION:		
NAME OF SUBSCRIBER	STREET ADDRESS CITY STATE ZIP	
SUBSCRIBER ID NUMBER	GROUP NUMBER	GROUP NAME
NAME OF DEPENDENT		BIRTH DATE MO. DAY YR.
PHYSICIAN INFORMATION:		
NAME OF PHYSICIAN (PLEASE PRINT):		
NPI/TIN#:	SPECIALTY:	
STREET ADDRESS	CITY	STATE ZIP
TELEPHONE #	FAX#	
CLINICAL INFORMATION:		
NATURE OF DISABILITY (PLEASE INCLUDE CLINICAL DOCUMENTATION TO SUPPORT YOUR DIAGNOSIS AND PROGNOSIS OF THIS DISABILITY):		
REMARKS:		
APPROXIMATE DATE OF ONSET OF DISABILITY:	ESTIMATED DURATION OF DISABILITY:	
IS THIS DISABILITY PERMANENT OR TEMPORARY?		
CERTIFICATION:		

I certify that the adult dependent referenced above and on the Request for Coverage for an Adult Dependent due to Disability form isn't capable of self-support because of a chronic mental or physical disability.

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Physician's Signature Date

NOTICE: Discrimination is Against the Law

Blue Cross and Blue Shield of Vermont (BCBSVT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex.

BCBSVT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

BCBSVT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, please call (800) 247-2583. If you would like to file a grievance because you believe that BCBSVT has failed to provide services or discriminated on the basis of race, color, national origin, age, disability, gender identity or sex, contact:

Civil Rights Coordinator
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601
(802) 371-3394
TDD/TTY: (800) 535-2227
civilrightscoordinator@bcbsvt.com

You can file a grievance by mail, or email at the contacts above. If you need assistance, 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 Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019
(800) 537-7697 (TDD)

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

For free language-assistance services, call (800) 247-2583.

ARABIC

للحصول على خدمات المساعدة اللغوية المجانية، اتصل على الرقم 247-2583 (800).

CHINESE

如需免費語言協助服務，請致電 (800) 247-2583。

CUSHITE (OROMO)

Tajaajila gargaarsa afaan hiikuu kaffaltii malee argachuuf (800) 247-2583 bilbilaa.

FRENCH

Pour obtenir des services d'assistance linguistique gratuits, appelez le (800) 247-2583.

GERMAN

Kostenlose fremdsprachliche Unterstützung erhalten Sie unter (800) 247-2583.

ITALIAN

Per i servizi gratuiti di assistenza linguistica, chiamare il numero (800) 247-2583.

JAPANESE

無料の通訳サービスのご利用は、(800) 247-2583までお電話ください。

NEPALI

नि:शुल्क भाषा सहायता सेवाहरूका लागि, (800) 247-2583 मा कल गर्नुहोस्।

PORTUGUESE

Para serviços gratuitos de assistência linguística, ligue para o (800) 247-2583.

RUSSIAN

Чтобы получить бесплатные услуги переводчика, позвоните по телефону (800) 247-2583.

SERBO-CROATIAN (SERBIAN)

Za besplatnu uslugu prevođenja, pozovite na broj (800) 247-2583.

SPANISH

Para servicios gratuitos de asistencia con el idioma, llame al (800) 247-2583.

TAGALOG

Para sa libreng mga serbisyo ng tulong pangwika, tumawag sa (800) 247-2583.

THAI

สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

VIETNAMESE

Để biết các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi số (800) 247-2583.

BlueCross BlueShield of Vermont