

# Application for Coverage Form

of Handicapped Dependent Child



## To be completed by the member:

Name \_\_\_\_\_  
Last (Sr., Jr., etc.) First MI

Member ID No. \_\_\_\_\_ Social Security No. \_\_\_\_\_

Residential Address \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State ZIP Code + 4 County

Mailing Address \_\_\_\_\_  
if different from residential address  
Street/P.O. Box  
\_\_\_\_\_  
City State ZIP Code + 4 County

Name of Handicapped Dependent \_\_\_\_\_

Dependent's Address \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State ZIP Code + 4 County

Dependent's Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Is dependent married?  Yes  No

Relationship to Applicant:  Child  Stepchild  Legal Guardian  Legal Custody

Are you responsible for the chief support and maintenance of the dependent child?  Yes  No

Is dependent an established beneficiary under Medicare or receiving SSA/SSI disability benefits?  Yes  No

**If yes, only complete Section 1 and submit verification. If no, complete sections 1 and 2.**

Has the dependent had any income during the past year?  Yes  No

If yes, please state the source of income \_\_\_\_\_ and the amount \_\_\_\_\_

Physician's name \_\_\_\_\_  
Please Print

List other members of the health care team (i.e., specialist in rehabilitation or mental health care).

\_\_\_\_\_  
\_\_\_\_\_

**Member signature**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## To be completed by the physician:

Diagnosis of condition causing disability. Indicate the severity:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date dependent was last treated \_\_\_\_/\_\_\_\_/\_\_\_\_

Prognosis (estimate in months or years): \_\_\_\_\_

Is dependent **incapable** of self-support by reason of mental or physical disability?  Yes  No

Section 1

Section 2

Is the dependent now confined to an institution?

 Yes

 No

If yes, give name of institution: \_\_\_\_\_

Address of Physician \_\_\_\_\_  
Street

\_\_\_\_\_

City

State

ZIP Code + 4

County

**Physician signature** \_\_\_\_\_

**Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

### Handicapped dependent child qualifications for eligibility:

- The child must be incapable of self-sustaining employment by reason of physical handicap or by reason of mental retardation or emotional illness if the member has legal guardianship or conservatorship of the child due to the retardation or emotional illness.
- The child must be chiefly dependent upon the member for support and maintenance.
- At the time application for handicapped coverage is made, the child must be unmarried and at the age listed as the maximum age for dependents in the insurance contract unless otherwise stated in the contract. The child, if approved for handicapped dependent status, will lose coverage if he/she marries unless the member continues after the marriage to have guardianship or conservatorship of the child due to the child's mental retardation or emotional illness.
- The member must be covered under a family policy.
- Coverage will be considered only for dependents who would otherwise be covered by a family policy as children of the member.
- Approval or disapproval will be determined by Blue Cross and Blue Shield of Kansas, Inc., and will be based upon the information provided on application for coverage or otherwise available or made available to Blue Cross and Blue Shield of Kansas, Inc.

**Please complete and return to:**

**Blue Cross and Blue Shield of Kansas, Inc.**

**1133 SW Topeka Blvd.**

**Topeka, KS 66629-0001**