Application for Coverage Form

of Handicapped Dependent Child

BlueCross BlueShield of Kansas
www.bcbsks.com

Section 1

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** ____/____/____

Section 2

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

Please continue on other side.→

Section 2 (cont'd)

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** _____/_____/_____

Section 3

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

This information is being furnished in compliance with applicable federal regulations.

This Notice has important information. This notice has important information about your application or coverage through Blue Cross and Blue Shield of Kansas. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Please call 1-800-432-3990.

Discrimination is against the law.

Blue Cross and Blue Shield of Kansas (BCBSKS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BCBSKS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Kansas:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Holly Graves.

If you believe that BCBSKS 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:

Holly Graves, Director, Individual Sales and Customer Service, 1133 S.W. Topeka Blvd., Topeka, KS 66629-0001,
1-800-432-3990, TTY: 1-800-766-3777, Fax: 785-290-0711, CSC@bcbsks.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Holly Graves 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
1-800-368-1019, 800-537-7697 (TDD)

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

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

اتصل برقم خدمة العملاء الموجود على بطاقة هُويتك للحصول على المساعدة باللغة العربية.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

Ligue para o número de telefone de atendimento ao cliente exibido no seu cartão de identificação para obter ajuda em português.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

日本語でのサポートは、ID カードに記載のカスタマーサービス番号までお電話でお問い合わせください。

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Rufen Sie den Kundendienst unter der Nummer auf Ihrer ID-Karte an, um Hilfestellung in deutscher Sprache zu erhalten.

برای دریافت راهنمایی به زبان فارسی ، با شماره خدمات مشتری که بر روی کارت شناسایی شما درج شده است تماسبگیرید..