



**BlueCross BlueShield
of Illinois**

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association.

P.O. Box 805107
Chicago, IL 60680-4112

DISABLED DEPENDENT CERTIFICATION

Date:

1. Name of Employee (Print – last, first & middle initial) NAME:		1a. Blue Cross Blue Shield Numbers Group Number: Member ID Number:	
2. Employee's Address (number, street, city, state & zip code) Address:			
3. Dependent's Name Name:		3a. Dependent's Birthdate (Month, Day, Year) / /	3b. Dependent's Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
3c. Dependent's Relationship to Employee		3d. Dependent's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	3e. Dependent's Age When Disability Occurred

4. Is dependent permanently residing in your household? Yes No - If 'No', please explain on reverse side

5. Is this person dependent upon you for support? Yes No

If 'Yes', what percentage of support do you contribute? _____ %

5a. Is dependent listed as a dependent on your last Federal Income Tax Return? Yes No

6. Was dependent ever employed? Yes No

6a. Is dependent now employed? Yes No

7. Was dependent covered under your present employer's insurance program immediately prior to attainment of age 26?
 Yes No

8. Is dependent now covered under Medicare or any other hospital-medical coverage? Yes No

8a. If answer is 'Yes', furnish name of insurance company and group, certificate or agreement number on reverse side of this form.

Upon presentation of the original or a photo-copy of this signed authorization, I authorize any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, or other person or firm to provide Blue Cross and Blue Shield information, including copies of records, concerning advice, care or treatment provided to the dependent named above including, without limitation, information relating to mental illness, use of drugs or alcohol.

I understand that such information will be used by Blue Cross and Blue Shield for the purpose of certifying the above name dependent as disabled for purpose of coverage under my health insurance. I understand that I or any other authorized representative will receive a copy of this authorization upon request.

This authorization is valid from the date signed for a period of two and one-half years.

I certify that the above information is correct and to the best of my knowledge and belief.

Signature of Employee

Date Signed

