

Regence BlueShield 1800 Ninth Avenue Seattle, WA 98101 Please return the completed form. By Mail: PO Box 1271 Portland, OR 97207-1271 By Fax: 1 (866) 303-5117

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

mployee's Address       City       State       ZIP Code       Greup Number         apendent's Name       Dependent's Birthdate         apendent's Relationship to Employee       Dependent's Martial Status         apendent's Relationship to Employee       Dependent's Martial Status         apendent's Relationship to Employee       Dependent's Martial Status         apendent's Address (if not reside with employee)       City       State       ZIP Code         idependent currently employed?       Yes       No       Date Employment Began       Average Hours Worked Per Week       Average H	mployee's Name	DENT S ELIGIBILITY (10 D	T'S ELIGIBILITY (to be completed by the Em		
apendent's Name   apendent's Relationship to Employee   apendent's Relationship to Employee   apendent's Relationship to Employee   apendent's Relationship to Employee   apendent's Address   dependent currently employed?   dependent's Name   asse explain why dependent does not reside with employee.   dependent currently employed?   dependent's Marined   apendent's Name   aurent Employer's Name   aurent Employer's Name   aurent Employer's Name   arrent Employer's Name   arrent Employer's Address   City   State   ZIP Codi   as dependent previously employed?   Yes   No   Dates of Employment Lengtoper's Name   arrent Employer's Address   City   State   ZIP Codi   as dependent previously employed?   Yes   No   pendent's Previous Employer's Name   appendent's Previous Employer's Name   appendent's Previous Employer's Address   City   State   ZIP Codi   opes dependent have other health insurance coverage?   yes, please provide the name of the carrier, employee name, policy number and carrier's phone number:   the dependent eligible for or have Medicare coverage?   yes, please provide the name of the carrier, employee take and the Medicare Number (please include the alpha prefix):   as the dependent been declared disabled by the Social Security Administration?   yes,		City	State ZID Code		
appendent's Relationship to Employee       Dependent's Marital Status         gendent's Address (if not residing with employee)       City       State       ZIP Codi         dependent currently employed?       Yes       No       Date Employment Began	npioyee's Address	Спу	State ZIP Code		
ependent's Relationship to Employee       Dependent's Marital Status         gendent's Address (if not residing with employee)       City       State       ZIP Codi         lease explain why dependent does not reside with employee.	enendent's Name			Dependent's Birthdate	
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Please explain why dependent does not reside with employee.         a dependent currently employed?       Vas         > cosition Held				Single Married	
Position Held	Dependent's Address (if not residing with employee)		City	State ZIP Code	
Position Held	Please explain why dependent does not reside with e	mployee.			
Dependent's Current Employer's Name   City   State   ZIP Code   Was dependent previously employed?   Yes   No   Dates of Employment   average Hours Worked Per Week   Dependent's Previous Employer's Name   Dependent's Previous Employer's Name Dependent have other health insurance coverage?   Yes   No   Octiv   State   ZIP Code   Dependent's Previous Employer's Address   City   State   ZIP Code   Dependent have other health insurance coverage?   Yes   No   f yes, please provide the name of the carrier, employee name, policy number and carrier's phone number:   st he dependent eligible for or have Medicare coverage?   Yes   No   f yes, please provide the type of coverage, effective date and the Medicare Number (please include the alpha prefix):   Has the dependent set declared disabled by the Social Security Administration?   Yes   No   f yes, what is the date of acceptance?   (please attach a copy of the SSI acceptance letter)   What is the dependent's estimated meets the following criteria:   Name of incapacitated dependent (please print)   , meets the following criteria:   1) Has been continuously covered by health insurance as my dependent win no break in coverage of ance than 63 days;   2) Is incapable of self-sustaining employment due to incapacitation related to developmental disability, medicaliability, and/or mental disorder; and <td>s dependent currently employed?</td> <td></td> <td>Date Employment Began</td> <td></td>	s dependent currently employed?		Date Employment Began		
Was dependent previously employed?       Yes       No       Dates of Employment	Position Held		Average Hours Worked Per Week		
Was dependent previously employed?       Yes       No         Position Held	Dependent's Current Employer's Name				
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Position Held	Vas dependent previously employed?	No	Dates of Employment	to	
Dependent's Previous Employer's Name         Dependent's Previous Employer's Address         City       State         ZIP Code         Does dependent have other health insurance coverage?       Yes         No         f yes, please provide the name of the carrier, employee name, policy number and carrier's phone number:         s the dependent eligible for or have Medicare coverage?       Yes         As the dependent teligible for or have Medicare coverage?       Yes         As the dependent been declared disabled by the Social Security Administration?       Yes         Has the dependent been declared disabled by the Social Security Administration?       Yes         Yes, what is the date of acceptance?       (please attach a copy of the SSI acceptance letter)         What is the dependent's estimated       What is the percentage of dependent's financial support supplied by the contract holder         certify that	Position Held				
Does dependent have other health insurance coverage?  _Yes  _No f yes, please provide the name of the carrier, employee name, policy number and carrier's phone number: is the dependent eligible for or have Medicare coverage?  _Yes  _No f yes, please provide the type of coverage, effective date and the Medicare Number (please include the alpha prefix): Has the dependent been declared disabled by the Social Security Administration?  _Yes  _No f yes, what is the date of acceptance?					
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Name of incapacitated dependent (please print) <ol> <li>Has been continuously covered by health insurance as my dependent with no break in coverage of more than 63 days;</li> <li>Is incapable of self-sustaining employment due to incapacitation related to developmental disability, medical disability, and/or mental disorder; and</li> <li>For a child over age 26, is significantly dependent upon employee (and/or employee's spouse) for support and maintenance.</li> </ol>	f yes, please provide the type of coverage, effective of the second state of the secon		es 🗌 No	SI acceptance letter)	
<ol> <li>Has been continuously covered by health insurance as my dependent with no break in coverage of more than 63 days;</li> <li>Is incapable of self-sustaining employment due to incapacitation related to developmental disability, medical disability, and/or mental disorder; and</li> <li>For a child over age 26, is significantly dependent upon employee (and/or employee's spouse) for support and maintenance.</li> </ol>	f yes, please provide the type of coverage, effective of Has the dependent been declared disabled by the Sc f yes, what is the date of acceptance?		es No (please attach a copy of the S What is the percentage of dep	endent's	
3) For a child over age 26, is significantly dependent upon employee (and/or employee's spouse) for support and maintenance.	f yes, please provide the type of coverage, effective of has the dependent been declared disabled by the So yes, what is the date of acceptance?	cial Security Administration? □ Y	es No (please attach a copy of the S What is the percentage of dep financial support supplied by th	endent's ne contract holder	
Signature of Employee	A sthe dependent been declared disabled by the So yes, what is the date of acceptance?	acitated dependent (please print)	es No (please attach a copy of the S What is the percentage of dep financial support supplied by th	endent's ne contract holder	
	f yes, please provide the type of coverage, effective of Has the dependent been declared disabled by the So f yes, what is the date of acceptance?	acitated dependent (please print) urance as my dependent with no bre ue to incapacitation related to develo	es No (please attach a copy of the S What is the percentage of dep financial support supplied by th , meets the f ak in coverage of more than 63 da pmental disability, medical disabil	endent's ne contract holder following criteria: ays; ity, and/or mental disorder; and	

<b>SECTION 2 - STATEMENT OF INCAPA</b>	CITATION (to be comple	eted by the de	pendent's a	ttending physician*)		
Provider's Name				Provider's Telephone Number		
				( )		
Provider's Address	City	State	ZIP Code	Provider's Tax ID Number		
	Chy	Claid				
Patient's Name				Patient's Birthdate		
Date patient was last examined by attending physician	Noture of condition coupling inc	on opitur				
Date patient was last examined by attending physician			<b>4</b> .			
		Medical Disabili	•			
	Mental Disorder	Other (please e	xpiain)			
Incapacitation is:	Incapacitation is:					
	Temporary (estimated durat	ion is)		Permanent		
Partial% incapacitated	At what age did patient become	e incapacitated?				
Diagnosis of Condition Causing Incapacity: (Give as much detail as possible. Please give dates of surgery, forward laboratory data and results of special tests, such as x-rays, EKG's, EEG's, etc. If mental retardation is present, give severity of retardation and IQ test score. Attach additional pages as necessary.)						
Diagnosis						
Comments to Support Incapacity						
Is patient or will patient be capable of self-support?	Yes No					
If yes, from						
Is patient able to perform full or part-time work of any kind? Yes No						
Has patient previously been able to perform full or part-time work of any kind?						
Does patient have a job? Yes No Unkno	wn Do you know what duties the lf yes, please explain:	ne patient's job requ	ires? 🗌 Yes	□ No		
Attending Physician's Nar	ne (please print)		Attendi	ing Physician's Credentials		
<b>7</b>						
Signature of Attendir	ig Physician			Date		

\*The attending physician's statements regarding incapacitation are necessary and important for Regence's incapacitation determination; however Regence is not bound by the physician's conclusion.