Regence

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

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

Affidavit of Qualifying Incapacitated Dependent Eligibility for Groups of 100+

SECTION 1 - STATEMENT OF DEPENDENT'S ELIGIBILITY (to be completed by the Employee)

Employee's Name | ID Number

Employee's Address | City | State | ZIP Code (State xxxxx-xxxx) | Group Number

Dependent's Name | Dependent's Birthdate (mm/dd/yyyy)

Dependent's Relationship to Employee | Dependent's Marital Status ☐ Single ☐ Married

Dependent's Address (if not residing with employee) | City | State | ZIP Code (State xxxxx-xxxx)

Please explain why dependent does not reside with employee.

Is dependent currently employed? ☐ Yes ☐ No | Date Employment Began (mm/dd/yyyy)

Position Held | Average Hours Worked Per Week

Dependent's Current Employer's Name

Current Employer's Address | City | State | ZIP Code (State xxxxx-xxxx)

Was dependent previously employed? ☐ Yes ☐ No | Dates of Employment (mm/dd/yyyy) to (mm/dd/yyyy)

Position Held | Average Hours Worked Per Week

Dependent's Previous Employer's Name

Dependent's Previous Employer's Address | City | State | ZIP Code (State xxxxx-xxxx)

Does dependent have other health insurance coverage? ☐ Yes ☐ No
If 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
If 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
If yes, what is the date of acceptance? (mm/dd/yyyy) (please attach a copy of the SSI acceptance letter)

What is the dependent's estimated gross monthly income from all sources $

What is the percentage of dependent's financial support supplied by the contract holder %

I certify that _____ , meets the following criteria:
Name of incapacitated dependent (please print)

1) Has been continuously covered by health insurance as my dependent with no break in coverage of more than 63 days;
2) Is incapable of self-sustaining employment due to incapacitation related to developmental disability, medical disability, and/or mental disorder; and
3) For a child over age 26, is significantly dependent upon employee (and/or employee's spouse) for support and maintenance.

▶ _____ (mm/dd/yyyy)
Signature of Employee **Date**

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SECTION 2 - STATEMENT OF INCAPACITATION (to be completed by the dependent's attending physician*)

Provider's Name				Provider's Telephone Number
				(xxx) xxx-xxxx
Provider's Address	**City**	**State**	**ZIP Code**	**Provider's Tax ID Number**
		State	xxxxx-xxxx	
Patient's Name				**Patient's Birthdate**
				(mm/dd/yyyy)

Date patient was last examined by attending physician	Nature of condition causing incapacity:
(mm/dd/yyyy)	☐ Developmental Disability ☐ Medical Disability ☐ Mental Disorder ☐ Other (please explain) _____
Incapacitation is: ☐ Complete ☐ Partial _____ % incapacitated	Incapacitation is: ☐ Temporary (estimated duration is) _____ ☐ Permanent At what age did patient become 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? ☐ Yes ☐ No

Does patient have a job? ☐ Yes ☐ No ☐ Unknown	Do you know what duties the patient's job requires? ☐ Yes ☐ No If yes, please explain:

Attending Physician's Name (please print)	Attending Physician's Credentials
Signature of Attending Physician	(mm/dd/yyyy) **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.**