Application for Coverage

of dependent with disabilities

BlueCross BlueShield Kansas

Section 1 – Member Information

CLEAR DATA

First Name | MI | Mailing Address (if different from residential address)

Last Name | Suffix | City

Residential Address | State | ZIP Code | +4

City | Member ID Number

State | ZIP Code | +4 | County | Social Security Number

Section 2 – Dependent With Disabilities Information

First Name | MI | Residential Address

Last Name | Suffix | City

Date of Birth | State | ZIP Code | +4 | County

Is the dependent married? ☐ Yes ☐ No

Relationship to applicant: ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

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

Is dependent an established beneficiary under Medicare or receiving SSA/SSI disability benefits? ☐ Yes ☐ No
If yes, only complete Sections 1 and 2 and submit verification. If no, complete all sections of this form.

Has the dependent had any income during the past year? ☐ Yes ☐ No
If yes, please provide the following information:

Source of Income

Amount of Income

Physician's Name

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

Your signature required

Member's Signature | Date Signed

If you have dependent life coverage through Advance Insurance Company of Kansas (AICK), please fill out Form AICK 21 – Dependent with Disabilities Application Form and forward to AICK.

Please continue on the next page.

Section 3 – Information to be completed by physician

Diagnosis of condition causing disability; indicate the severity:

_____ /_____ /_____
Date Dependent Last Treated

Prognosis (estimate in months or years): _____

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

Is dependent now confined to an institution? ☐ Yes ☐ No
If yes, please provide the information below:

_____
Name of Institution

_____
Physician's Address

_____
City

_____ _____ _____ _____
State ZIP Code +4 County

Your signature required _____ _____ /_____ /_____
Physician's Signature Date Signed

Section 4 – Dependent with Disabiliites Qualifications for Eligibility

» The dependent must be incapable of self-sustaining employment by reason of physical disability or by reason of cognitive, intellectual or developmental disabilities or emotional illness if the member has legal guardianship or conservatorship of the dependent due to the cognitive or emotional illness.

» The dependent must be chiefly dependent upon the member for support and maintenance.

» At the time application for disability coverage is made, the dependent 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 dependent, if approved for disabled dependent status, will lose coverage if he/she marries unless the member continues after the marriage to have guardianship or conservatorship of the dependent due to the dependent's cognitive, intellectual or developmental disabilities 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 dependents 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 this form and return to:

Blue Cross and Blue Shield of Kansas, Inc.
1133 SW Topeka Blvd.
Topeka, KS 66629-0001