



**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: 200864      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



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**Disabled Dependent  
Physician Certification**

To: Attending Physician

Claim Number:  
Patient Name:  
Insured Number:  
Service Date:  
Provider Name:

Note: Any fee for the completion of this form is the responsibility of the employee.

1. Is dependent now incapable of self-support because of disability?  Yes  No
2. From what age has such disability existed continuously?  From Birth, or  From age \_\_\_\_\_
3. Nature of disability (please give as much detail as possible, otherwise, it may be necessary to contact you for more specific data). Use reverse side if necessary.

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4. Prognosis: \_\_\_\_\_

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Name of Physician (Print or Type)                      Degree                      Physician's Signature                      Date

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Address of Physician (Print or Type)