



# BlueCross BlueShield of North Carolina

An Independent Licensee of the  
Blue Cross and Blue Shield Association

**COVERAGE REQUEST FOR MENTALLY RETARDED  
OR PHYSICALLY HANDICAPPED CHILDREN  
REACHING THE AGE LIMIT STATED IN THE CERTIFICATE**

**INSTRUCTIONS:**

1. SELECT ONE OF THE OPTIONS AT RIGHT.
2. RETURN COMPLETED FORM TO:  
BCBSNC  
P.O. BOX 2400  
WINSTON-SALEM, NC 27102-2400

**OPTION SELECTION:** IF MY CHILD IS QUALIFIED, I SELECT THE OPTION CHECKED BELOW AND UNDERSTAND THAT THIS OPTION CANNOT BE CHANGED.

**OPTION 1**  COVER MY CHILD UNDER MY PRESENT CERTIFICATE (COMPLETE SELECTIONS A AND B BELOW).

**OPTION 2**  COVER MY CHILD UNDER A SEPARATE NONGROUP CERTIFICATE. (COMPLETE ONLY LINES 1, 2, 5, 8 AND 9 OF SECTION A; DO NOT COMPLETE SECTION B.)

**ANNUAL RECERTIFICATION REQUEST**

**SECTION A – TO BE COMPLETED BY SUBSCRIBER**

1.	NAME OF SUBSCRIBER	ADDRESS OF SUBSCRIBER	SUBSCRIBER ID NUMBER
2.	NAME OF DEPENDENT	ADDRESS OF DEPENDENT	DEPENDENT'S DATE OF BIRTH MONTH   DAY   YEAR
3.	SOCIAL SECURITY NUMBER OF DEPENDENT, IF ANY	DEPENDENT'S MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED	
4.	WAS DEPENDENT EVER INSTITUTIONALIZED? NO <input type="checkbox"/> YES <input type="checkbox"/>	IF YES, GIVE NAME AND ADDRESS OF INSTITUTION(S), AND	PERIOD CONFINED: FROM: TO:
5.	IS DEPENDENT ELIGIBLE FOR CARE UNDER FEDERAL, STATE OR LOCAL LAW? NO <input type="checkbox"/> YES <input type="checkbox"/>	IF YES, GIVE DETAILS	
6.	IS DEPENDENT ELIGIBLE FOR MEDICARE? NO <input type="checkbox"/> YES <input type="checkbox"/>	IF YES, GIVE EFFECTIVE DATES PART A _____ PART B _____	
7.	WAS, OR IS, DEPENDENT EMPLOYED FOR WAGES? NO <input type="checkbox"/> YES <input type="checkbox"/>	IF YES, GIVE NAME AND ADDRESS OF CURRENT OR LAST EMPLOYER AND DATE EMPLOYED	AVERAGE WEEKLY EARNING \$
8.	IF WAS EMPLOYED, REASON FOR TERMINATION?	DATE OF TERMINATION	
9.	IS DEPENDENT CHILD CURRENTLY COVERED UNDER YOUR PRESENT BCBSNC CERTIFICATE? NO <input type="checkbox"/> YES <input type="checkbox"/>	IS DEPENDENT CHILD CURRENTLY COVERED UNDER A SEPARATE BCBSNC CERTIFICATE? NO <input type="checkbox"/> YES <input type="checkbox"/>	IF YES, GIVE SUBSCRIBER ID NUMBER
10.	IS DEPENDENT CHILD CURRENTLY CLAIMED FOR INCOME TAX EXEMPTION UNDER THE U.S. INTERNAL REVENUE CODE? NO <input type="checkbox"/> YES <input type="checkbox"/>	IF YES, BY WHOM?	
11.	SIGNATURE OF SUBSCRIBER		DATE SIGNED

**SECTION B – TO BE COMPLETED BY CERTIFYING PHYSICIAN**

IS DEPENDENT PRESENTLY INCAPABLE OF SELF-SUSTAINING EMPLOYMENT BY REASON OF: <input type="checkbox"/> MENTAL RETARDATION <input type="checkbox"/> PHYSICAL HANDICAP	DATE OF INCAPACITATION
DIAGNOSIS OF CONDITIONS CAUSING HANDICAPPED STATUS:	
WILL THIS DEPENDENT BE INCAPABLE OF SELF-SUSTAINING EMPLOYMENT FOR AN EXTENDED PERIOD OF ONE YEAR OR LONGER? NO <input type="checkbox"/> YES <input type="checkbox"/>	IF YES, IS HE PERMANENTLY DISABLED? NO <input type="checkbox"/> YES <input type="checkbox"/>
PLEASE USE THIS SPACE FOR REMARKS – GIVE AS MUCH DETAIL AS WILL BE HELPFUL.	
IF ADMITTED AS INPATIENT, GIVE NAME OF HOSPITAL:	DATE ADMITTED:
NAME OF CERTIFYING PHYSICIAN:	ADDRESS
SIGNATURE OF CERTIFYING PHYSICIAN:	DATE SIGNED

**FOR BCBSNC USE ONLY**

	BY	DATE	REMARKS:
REC'D.			
APP'D.			
EFPEC.			