HIGHMARK Delaware

DISABLED CHILD APPLICATION

INSTRUCTIONS

1. Parent should complete the first page of the form, enter information on the first line on page two and then forward to the doctor who treats your child for this disability to complete the second page. Please mail or fax the completed form as instructed on page two.
2. Incomplete applications will be returned.
3. Please read the eligibility requirements below for a disabled child. Highmark Blue Cross Blue Shield Delaware (Highmark DE) as final approval on all applications.

ELIGIBILITY REQUIREMENTS

A disabled child can be covered after the maximum dependent child age allowed on the policy if all the following requirements are met:

a) Child is unmarried

b) Child is covered as a dependent by a parent as of the date the child reaches the maximum dependent child age

c) Child receives 50% or more of support by his/her parent

d) Child has a disability that:
- occurred prior to reaching the maximum dependent child age; and
- is expected to last more than 12 months or is terminal in nature; and
- is so severe the child is incapable of self-support

e) Child is not eligible for coverage under:
- Another health plan or
- Medicare or Medicaid (unless federal or state law requires otherwise)

SECTION ONE - CUSTOMER INFORMATION

Customer's Last Name (last name of parent)	First Name	Middle Initial	Telephone Number (include area code)

Customer's Address (street, city, state, zip code)

Identification Number	Account Number or Employer Name	Do you and/or another parent provide more than 50% support for this dependent? ☐ **Yes** ☐ **No**

SECTION TWO - DEPENDENT INFORMATION

Dependent's Last Name	First Name	Middle Initial	Marital Status ☐ **Single** ☐ **Married**

Dependent's Birth Date / /	Dependent's Relationship To Customer ☐ Son ☐ Daughter ☐ Other *(explain)*:	Dependent's Address (If different than above)

Is dependent employed? ☐ **Yes** ☐ **No**	If Yes, Name of Employer	Hours Worked ________ Per week	Rate of Pay $_________ Per hour	Type of Work Performed

Question	Details
Is this dependent eligible for coverage under another health plan? ☐ **Yes** ☐ **No**	If **Yes**, Please explain. If Plan is with Highmark DE, provide ID Number.
Is this dependent eligible for Medicare? ☐ **Yes** ☐ **No**	If **Yes**, provide Medicare Claim Number and Part A and Part B Effective Date.
Is this dependent eligible for Medicaid? ☐ **Yes** ☐ **No**	If **Yes**, provide Medicaid Number and Effective Date.

Has child been covered by parent continuously prior to (and after if applicable) reaching the maximum dependent child age? ☐ **Yes** ☐ **No**
If yes, and carrier was not Highmark DE, please provide HIPAA certificates of coverage to show child was continuously insured.

SECTION THREE - TERMS AND SIGNATURE

I REQUEST COVERAGE FOR THE DEPENDENT CHILD NAMED ABOVE WHO IS DISABLED.

I understand and agree that:

1. Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer, association and Highmark Blue Cross Blue Shield Delaware.
2. I certify that all representations and information supplied by me are true. My coverage shall be void if any part of this application is false or incomplete.
3. I authorize any hospital, physician, professional review organization and any and all other providers of service to disclose and furnish to Highmark Blue Cross Blue Shield Delaware and/or its agents any and all records relating to the disabled child named in this application for whom services or benefits have been sought or to whom services or benefits have been provided, including a complete diagnosis and medical information.

I HAVE READ AND DO AGREE TO THE ABOVE TERMS	Date
Signature of Customer: X	/ /

ENR-187 (9-12)

IMPORTANT!

PLEASE HAVE PHYSICIAN COMPLETE THIS SIDE OF THIS APPLICATION.

DISABLED CHILD APPLICATION

Dependent's Last Name	First Name	Middle Initial	Dependent's Birth Date / /

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Physician's Name			
Physician's Address (street, city, state, zip code)			
Physician's Telephone Number (include area code)			
Diagnosis of Condition Causing Disability (Indicate degree of severity)			
Is this disability permanent? ☐ **Yes** ☐ **No**	If No, will the disability last at least twelve months? ☐ **Yes** ☐ **No**		
Current medications or treatment for this disability			
Treatment or services that may be needed in the near future for this disability			
Date child was last treated (month, day, year)	Is child incapable of self-support by reason of a mental/physical disability? ☐ **Yes** ☐ **No**	If Yes, date child became incapable of self-support (month, day, year)	
Is child confined in an institution? ☐ **Yes** ☐ **No**	If **Yes**, Name of Institution		
Signature of Physician:	**Please Print Name:**	Date / /	

INSTRUCTIONS

1. The form needs to be completed in its entirety (front and back pages).
2. Please see eligibility requirements for a disabled child at the top of page 1.
3. Send this form to:

Highmark Blue Cross Blue Shield Delaware
Underwriting 1-8-10
PO Box 1991
Wilmington, DE 18999-1991

Or fax the form to: 1-877-731-4883

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