DISABLED DEPENDENT CERTIFICATION

PLEASE READ CAREFULLY

The " Disabled Dependent Certification" form is used to determine if your adult dependent child meets the plan’s eligibility requirements for continued coverage after the age limit is reached.

IMPORTANT NOTE
The inability to find employment or a reduction in work force is, of themselves, NOT evidence of eligibility for continuation of coverage.

INSTRUCTIONS
You or your physician may submit the information requested in this " Disabled Dependent Certification" form. Please complete all required sections and sign the attestation statement at the end.

Step 1: Complete all applicable sections of the Disabled Dependent Certification attached form.

Step 2: Subscriber must complete and sign the applicable fields.

Step 3: Licensed physician must complete and sign the applicable fields. (where applicable)

Step 4: Include one of the following information:

- Copy of the Social Security Disability Insurance* (SSDI) Award Letter (where applicable)
- Copy of the active Court Order (where applicable) example: Legal Guardianship
  - If copy of SSDI OR Court Order are not available: the Physician’s attestation must be completed, and signature required
- Physician Attestation (where applicable)
  - If child has only SSI** and not SSDI*, the child’s physician will need to complete section 3; the Physician’s Statement.

Step 5: Send to:
Premera
Membership & Billing, MS 137
PO Box 91059
Seattle, WA 98111-9159

If you have any questions regarding the attached form please contact Customer Service at the number located on the back of your ID card.

CONDITIONS OF ELIGIBILITY
Under the provisions of the Contract coverage, a dependent who is mentally or physically disabled may continue coverage to any age provided the dependent is:

1. Dependent became disabled before reaching the limiting age (over the age of 25).
2. Dependent must be incapacitated or incapable of self-sustaining employment.
3. Dependent must be mentally or physically disabled prior to attainment of the age where coverage would otherwise be terminated.

Social Security Disability Insurance is the Federal Insurance Program
Supplemental Security Income (SSI) program pays benefits to disabled adults and children who have limited income and resources.

** The attending physician’s statements regarding disability status are necessary and important for Premera; however, Premera is not bound by the physician’s conclusion.
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**ALL SECTIONS MUST BE COMPLETED PER INSTRUCTIONS (review carefully)**

### SECTION 1: SUBSCRIBER INFORMATION

<table>
<thead>
<tr>
<th>Full name of Subscriber: (last, first, middle)</th>
<th>Subscriber ID#:</th>
<th>Group #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address:</td>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td></td>
<td>Zip code:</td>
<td>Telephone No:</td>
</tr>
</tbody>
</table>

### SECTION 2: DEPENDENT INFORMATION

<table>
<thead>
<tr>
<th>Full Name of disabled dependent: (last, first, middle)</th>
<th>Date of birth:</th>
<th>Relationship to Subscriber:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Status: ☐ Married ☐ Single</td>
<td>Address: (if different than subscriber)</td>
<td></td>
</tr>
<tr>
<td>Sex: ☐ Male ☐ Female</td>
<td>Nature of disability:</td>
<td>Date of disability:</td>
</tr>
</tbody>
</table>

Does dependent currently have other/additional health insurance? (example: Medicare) ☐ Yes ☐ No
If Yes, provide responses in the fields below.

<table>
<thead>
<tr>
<th>Other/Additional Health Insurance Name:</th>
<th>Other Health Insurance ID Number:</th>
<th>Customer Service Number:</th>
</tr>
</thead>
</table>

Is the Other Health Insurance company *Primary* coverage for the dependent? ☐ Yes ☐ No

### SOCIAL SECURITY DISABILITY OR LEGAL GUARDIANSHIP SUPPORTING DOCUMENTS

<table>
<thead>
<tr>
<th>Has the dependent been declared disabled by the Social Security Administration?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ If Yes, (attach SSDI <em>and SSI</em>* document)</td>
</tr>
<tr>
<td>☐ If No, provide subscriber signature below and then continue to section 3</td>
</tr>
</tbody>
</table>

If yes, complete the following:
- Copy of the SSDI* Award letter
- Most recent monthly SSI** statement
  and/or
- Applicable court order
- Sign on the Subscriber signature line and STOP

If no, provide subscriber signature and then continue to section 3.

**Subscriber Signature:**

<table>
<thead>
<tr>
<th>Has the dependent been placed in Legal Guardianship by a court order?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ If Yes, (attach active court order)</td>
</tr>
<tr>
<td>☐ If No, provide subscriber signature below and then continue to section 3</td>
</tr>
</tbody>
</table>

If yes, complete the following:
- Attach the copy of the active Legal Guardianship court order
- Sign on the Subscriber signature line and STOP

If no, provide subscriber signature below and then continue to section 3.

**Subscriber Signature:**

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**The attending physician's statements regarding disability status are necessary and important for Premera; however, Premera is not bound by the physician's conclusion.**

008822 (09-01-2019) www.premera.com Premera Blue Cross Blue Shield of Alaska is an Independent Licensee of the Blue Cross Blue Shield Association
**SUBSCRIBER SIGNATURE** – must be signed for the form to be valid

Please note: it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I certify/attest that <Dependent’s Name> meets the following criteria:

1. The dependent became disabled before reaching the limiting age; and
2. Is incapable of self-sustaining employment due to disability; and
3. The dependent relies primarily upon Subscriber (and/or spouse) for support and maintenance.

Subscriber’s Signature

Date of Signature

(My signature attests that the above statements are true and if requested I can provide further substantiating documentation.)

**SECTION 3: PHYSICIAN’S INFORMATION** – the following must be completed, signed and certified by a physician

IMPORTANT NOTE
The inability to find employment or a reduction in work force is, of themselves, NOT evidence of eligibility for continuation of coverage

ATTENDING PHYSICIAN’S STATEMENT

- It is imperative that we have complete medical proof of your dependent’s disability. This should be supplied by the physician(s) who treated your dependent during the entire period of disability.
- The inability to find employment or a reduction in work force is, of themselves, NOT evidence of eligibility for continuation of coverage.

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Provider Mailing Address:</th>
<th>Provider Contact Phone:</th>
<th>Provider Fax Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Patient’s last exam: (The application date and date of the last exam must be within the past year)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability is Complete 100%</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Disability is: Partial ____%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is this disability temporary or permanent?</td>
<td>Temporary</td>
<td>Permanent</td>
<td></td>
</tr>
<tr>
<td>If temporary, estimated duration:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Diagnosis causing disability: (provide ICD-10 and standard nomenclature of condition)

Will dependent/patient be capable of self-support | Yes | No. If yes, when (date)

Please note: it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signature of Attending Physician (Print / Credentials): __________________________

Date of Signature: __________________________

(My signature attests that the above statements are true and if requested I can provide further substantiating documentation.)
Discrimination is Against the Law

Premera Blue Cross Blue Shield of Alaska complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5562, TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 505F, HH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7597 (TDD)

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross Blue Shield of Alaska. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-508-4722 (TTY: 800-842-5357).

中文 (Chinese):
本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross Blue Shield of Alaska 提交的申請或保費的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-508-4722 (TTY: 800-842-5357).

Oromoo (Cushite):

Français (French):

Kreyòl ayisyen (Creole):
AHi si a gen Entfòmsyon Enpòtan ladan. AHi si a kapab genyen entfòmsyon enpòtan konsènan aplikasyon w lan osawa konsènan kouvèti asirans lan atrafè Premera Blue Cross Blue Shield of Alaska. Kapab genyen det ki enpòtan nan aHi si a. Ou ka gen pou pran Kid ak ouyo avan sjen sen dlo moun ka menen kouvèti asirans sante w lan osawa pou yo ka ede w ak ak ou yo yo. Se dw a pou resoewa entfòmsyon sa a ki asistans nan lang ou pale a, sa ou pou gen pou peye ou sa. Rele nan 800-508-4722 (TTY: 800-842-5357).

Deutsche (German):

Hmoob (Hmong):

Iloko (Ilocano):
Daytoy a Pakdaa ket naglaon ili Napateg nga Impormasion. Daytoy a pakdaa mabalin nga adda ket naglaon ili napateg nga impormasion mainpenggip ili aplikasyonoy wemono coverage babaen ili Premera Blue Cross Blue Shield of Alaska. Daytoy ket mabalin dagiti importanta a peta ili daytoy a pakdaa. Mabalin nga adda rumbeng nga aramidengy nga addang sakbag dagiti partikular a nalituding nga addaw tapno magatinaedoy ti coverage ti salun-ayo wemono tulong kadagit gastos. Adda karbenganyo a mangala ili daytoy nga impormasion kon tulong ti bukedoy a pagssaa nga awan ti bayadanyo. Tumawag ti numero nga 800-508-4722 (TTY: 800-842-5357).

Italiano (Italian):