Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association

Please return the completed form.
By Mail: PO Box 1271 MS5C
Portland, OR 97207-1271
By Fax: 1 (866) 303-5117

Affidavit of Qualifying Incapacitated Dependent Eligibility

SECTION 1 - STATEMENT OF DEPENDENT'S ELIGIBILITY (to be completed by the Employee)

Employee's Name	ID Number
Employee's Address / City / State / ZIP Code	Group Number
Dependent's Name	Dependent's Birthdate
Dependent's Relationship to Employee	Dependent's Marital Status

Dependent's Address (if not residing with Employee) City State ZIP Code

Please explain why dependent does not reside with employee.

Is dependent currently employed? ☐ Yes ☐ No

Date Employment Began ______

Position Held ______

Average Hours Worked Per Week ______

Dependent's Current Employer's Name

Current Employer's Address City State ZIP Code

Was dependent previously employed? ☐ Yes ☐ No

Dates of Employment ______ to ______

Position Held ______

Average Hours Worked Per Week ______

Dependent's Previous Employer's Name

Dependent's Previous Employer's Address City State ZIP Code

Does dependent have other health insurance coverage? ☐ Yes ☐ No
If yes, please provide the name of the carrier, Employee name, policy number and carrier's phone number:

Is the dependent eligible for or have Medicare coverage? ☐ Yes ☐ No
If yes, please provide the type of coverage, effective date and the Medicare Number (please include the alpha prefix):

Has the dependent been declared disabled by the Social Security Administration? ☐ Yes ☐ No

If yes, what is the date of acceptance? ______ (please attach a copy of the SSI acceptance letter)

What is the dependent's estimated gross monthly income from all sources $ ______

What is the percentage of dependent's financial support supplied by Employee ______ %

I certify that ______, meets the following criteria:
Name of incapacitated dependent (please print)

1) Has been continuously covered by health insurance as my dependent with no break in coverage of more than 63 days;
2) Is incapable of self-sustaining employment due to incapacitation related to developmental disability, medical disability, and/or mental disorder; and
3) Is significantly dependent upon Employee (and/or Employee's spouse) for support and maintenance.

______ **Signature of Employee** ______ **Date**

SECTION 2 - STATEMENT OF INCAPACITATION (to be completed by the dependent's attending physician*)

Provider's Name				Provider's Telephone Number ( )
Provider's Address	City	State	ZIP Code	Provider's Tax ID Number
Patient's Name				Patient's Birthdate

Date patient was last examined by attending physician	Nature of condition causing incapacity: ☐ Developmental Disability ☐ Medical Disability ☐ Mental Disorder ☐ Other (please explain) ________
Incapacitation is: ☐ Complete ☐ Partial ________ % incapacitated	Incapacitation is: ☐ Temporary (estimated duration is) ________ ☐ Permanent At what age did patient become incapacitated? ________

Diagnosis of Condition Causing Incapacity: *(Give as much detail as possible. Please give dates of surgery, forward laboratory data and results of special tests, such as x-rays, EKG's, EEG's, etc. If mental retardation is present, give severity of retardation and IQ test score. Attach additional pages as necessary.)*

Diagnosis ____

____

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____

____

Comments to Support Incapacity ____

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Is patient or will patient be capable of self-support? ☐ Yes ☐ No

If yes, from ____

Is patient able to perform full or part-time work of any kind? ☐ Yes ☐ No

Has patient previously been able to perform full or part-time work of any kind? ☐ Yes ☐ No

Does patient have a job? ☐ Yes ☐ No ☐ Unknown	Do you know what duties the patient's job requires? ☐ Yes ☐ No If yes, please explain:

____ Attending Physician's Name (please print)

____ Attending Physician's Credentials

____ **Signature of Attending Physician**

____ **Date**

***The attending physician's statements regarding incapacitation are necessary and important for Regence's incapacitation determination; however Regence is not bound by the physician's conclusion.**