



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 1200  
Portland, OR 97207-1200  
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____ %			
<p>I certify that _____, meets the following criteria:</p> <p style="text-align: center;">Name of incapacitated dependent (please print)</p> <ol style="list-style-type: none"> <li>1) Has been continuously covered by health insurance as my dependent with no break in coverage of more than 63 days;</li> <li>2) Is incapable of self-sustaining employment due to incapacitation related to developmental disability, medical disability, and/or mental disorder; and</li> <li>3) Is significantly dependent upon Employee (and/or Employee's spouse) for support and maintenance.</li> </ol>						
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
Patient's Name			Provider's Tax ID Number
			Patient's Birthdate

Date patient was last examined by attending physician	Nature of condition causing incapacity: <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Medical Disability <input type="checkbox"/> Mental Disorder <input type="checkbox"/> Other (please explain) _____
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Incapacitation is: <input type="checkbox"/> Complete <input type="checkbox"/> Partial _____ % incapacitated	Incapacitation is: <input type="checkbox"/> Temporary (estimated duration is) _____ <input type="checkbox"/> Permanent At what age did patient become incapacitated? _____
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**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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Comments to Support Incapacity \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Do you know what duties the patient's job requires? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
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_____	_____
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.

