BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

SUBSCRIBER REQUEST FOR COVERAGE FOR AN ADULT DEPENDENT DUE TO DISABILITY

To be completed by Subscriber (Must be accompanied by Medical Certification Form)

MEMBER INFORMATION

Name of Subscriber:		Subscriber ID Number:	
Street address:			
City:		State:	Zip Code:
Group Name:		Group Number:	
Name of Dependent:	Birth Date:	Marital Status (Check One):	
		☐ Single	☐ Widowed
		☐ Married	☐ Divorced
		☐ Separated	☐ Other

Section One

Is Dependent Employed for Wages? Yes ☐ No ☐

If yes, please list Name of Employer and approximate number of hours worked per week: Yes ☐ No ☐

Is dependent confined to an institution or attending school? Yes ☐ No ☐

If yes, give Name of Institution or School and date of admission:

Is your son or daughter chiefly dependent upon you for support? Yes ☐ No ☐

Is dependent entitled to receive Medicare Benefits? Yes ☐ Part A ☐ Part B ☐ (Please check all that apply) No ☐

How long has your dependent's disability existed?

Section Two

Please continue coverage for my adult dependent child under my Blue Cross and Blue Shield of Vermont membership.

I understand that my dependent may be covered under my membership only so long as:

- He or she is incapable of self-support because of a physical or mental disability that existed prior to age 26, and
- I furnish more than half of this dependent's support.

I also understand that:

- It is my responsiblity to notify Blue Cross and Blue Shield of Vermont of any change in the status of my dependent's disability, and that
- Blue Cross and Blue Shield of Vermont shall have the right to require recertification as to the eligibility for continuation of coverage as a disabled dependent.

The information I've supplied above, is correct to the best of my knowledge.

Subscriber's Signature _____ Date _____

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MEDICAL CERTIFICATION FOR COVERAGE FOR AN ADULT DEPENDENT DUE TO DISABILITY

To be completed by the Adult Dependent's Primary Health Care Provider or Attending Specialist
(Must be accompanied by Subscriber Request Form)

MEMBER INFORMATION		
Name of Subscriber:	Subscriber ID Number:	
Street address:		
City:	State:	Zip Code:
Group Name:	Group Number:	
Name of Dependent:	Birth Date:	

PHYSICIAN INFORMATION		
Name of Physician (Please Print):		
NPI/TIN #:	Speciality:	
Street Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	

CLINICAL INFORMATION	
Nature of Disability (Please include clinical documentation to support your diagnosis and prognosis of this disability):	
Remarks:	
Approximate Date of Onset of Disability:	Estimated Duration of Disability:
Is this Disability Permanent or Temporary?	

CERTIFICATION

I certified that the adult dependent referenced above and on the Request for Coverage for an Adult Dependent due to Disability form isn't capable of self-support because of a chronic mental or physical disability.

Physician's Signature

Date

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Non-discrimination Disclaimer Notice

bluecrossvt.org

DISCLAIMERS

General Exclusions

While your health plan covers a broad array of necessary services and supplies, it doesn't cover every possible medical expense. If you would like to review the list of general exclusions before enrolling, visit **bluecrossvt.org/contracts**, click on the plan in which you are enrolling and read the chapter entitled "General Exclusions." Once you enroll, you will receive an Outline of Coverage and a link to your Certificate of Coverage. Please read both carefully as they govern your specific benefits.

How We Protect Your Privacy

The law requires us to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law. You may find information about our privacy practices at **bluecrossvt.org/privacypolicies**.

NOTICE: Discrimination is Against the Law

Blue Cross® and Blue Shield® of Vermont (Blue Cross VT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-status.

Blue Cross VT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

Blue Cross VT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, contact **civilrightscoordinator@bcbsvt.com**.

If you believe that Blue Cross VT has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-Status, you can file a grievance with: Kienan D. Christianson, Civil Rights Coordinator, P.O. Box 186, Montpelier, VT 05601-0186, call (800) 247-2583 (TTY/TDD: 711), fax (802) 229-0511, or email **civilrightscoordinator@bcbsvt.com**. You can file a grievance in person, by mail, via fax, or by email. If you need help filing a grievance, Kienan D. Christianson, 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 or 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 509F,
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
https://www.hhs.gov/ocr/complaints/index.html

For free language-assistance service, call (800) 247-2583 (TTY/TDD: 711).

ARABIC	للحصول على خدمات المساعدة اللغوية المجانية ، اتصل (800) 247 2583 (TTY/TDD: 711). lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583 (TTY/TDD: 711).
CHINESE	如需免费语言协助服务，请致电，(800) 247-2583 (TTY/TDD: 711). Rú xū miǎnfèi yǔyán xiézhù fúwù, qǐng zhìdiàn (800) 247-2583 TTY/TDD: 711).
CUSHITE (OROMO)	Tajaajila gargaarsa afaanii bilisaa argachuuf, (800) 247-2583 (TTY/TDD: 711) bilbili.
FRENCH	Pour des services d’assistance linguistique gratuits, appelez le (800) 247-2583 (TTY/TDD: 711).
GERMAN	Für kostenlose Sprachunterstützungsdienste rufen Sie (800) 247-2583 (TTY/TDD: 711) an.

ITALIAN	Per i servizi di assistenza linguistica gratuiti, chiamare il numero (800) 247-2583 (TTY/TDD: 711).
JAPANESE	無料の言語支援サービスについては, (800) 247-2583 (TTY/TDD: 711). Muryō no gengo shien sābisu ni tsuite wa, (800) 247-2583 (TTY/TDD: 711) made o denwa kudasai.
NEPALI	निःशुल्क भाषा-सहायता सेवाहरूको लागि, कल गर्नुहोस् , (800) 247-2583 (TTY/TDD: 711). Niḥśulka bhāṣā-sahāyatā sēvāharūkō lāgi, kala garnuhōs (800) 247-2583 (TTY/TDD: 711).
PORTUGUESE	Para serviços gratuitos de assistência linguística, ligue para (800) 247-2583 (TTY/TDD: 711).
RUSSIAN	Чтобы получить бесплатную языковую помощь, позвоните по телефону (800) 247-2583 (TTY/TDD: 711).

SERBO-CROATIAN (SERBIAN)	За бесплатне услуге језичке помоћи позовите (800) 247-2583 (TTY/TDD: 711). Za besplatne usluge jezičke pomoći pozovite (800) 247-2583 (TTY/TDD: 711).
SPANISH	Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583 (TTY/TDD: 711).
TAGALOG	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 247-2583 (TTY/TDD: 711).
THAI	สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร,(800) 247-2583 (TTY/TDD: 711). S̄ả h̄rạb brikār ch̀wyh̄elū̱x d̂ān p̣hās̄'ā frī thor (800) 247-2583 (TTY/TDD: 711).

UKRAINIAN	Щоб отримати безкоштовні мовні послуги, телефонуйте (800) 247-2583 (TTY/TDD: 711). Shchob otrymaty bezkoshtovni movni posluhy, telefonuyte (800) 247-2583 (TTY/TDD: 711)
VIETNAMESE	Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583 (TTY/TDD: 711).