Application for Continuation of Coverage

For a Child Who is Incapable of Self-sustaining Employment by Reason of Mental or Physical Handicap and Who Has Reached the Limiting Age for Dependent Children Specified in the Contract.

Please Type or Print

SECTION I - TO BE COMPLETED BY SUBSCRIBER

Dependent Child's Name (Last, First, Initial)	Child's Sex ☐ Male ☐ Female	Child's Date of Birth Mo. Day Yr.	Relationship to Subscriber

Subscriber's Name (Last, First, Initial)	Identification No.	Group No. (if it appears on ID card)	Name of Subscriber's Employer

Subscriber's Address (number, street, city, state & zip code)

Child's Marital Status ☐ Single ☐ Widowed ☐ Married ☐ Divorced	Date Child's Disability Occurred	Is Child Permanently Residing In Your Household? ☐ Yes ☐ No If "No" Explain :

Is Child Dependent on You For Support? ☐ Yes ☐ No	If "Yes" What Part of Support Do You Contribute? (% of Total)	Is this dependent eligible as a federal tax exemption for this year? ☐ Yes ☐ No	Was Child Ever Employed? ☐ Yes ☐ No

Is Child Employed Now? ☐ Yes ☐ No	If Answer to Either of The Last Two Questions is "Yes" Give Name(s), Address(es) of Employer(s) and Date(s) Employed.

Is Dependent Eligible For Any Other Care Under Federal, State or Local Law? ☐ Yes ☐ No	If "Yes" Give Details
Do you or your Spouse Have Other Health Care Coverage? ☐ Yes ☐ No	If "Yes" Give Name and Address of Insurance Company

I have read the foregoing statements and declare them to be true and complete to the best of my knowledge. I hereby authorize any physician or other person who has attended my above named dependent child or who may hereafter attend or examine such child to disclose any knowledge or information thereby acquired by him to the Blue Cross and Blue Shield Plan named above.

Date	Signature of Subscriber	Soc. Sec. No. of Subscriber

SECTION II - TO BE COMPLETED BY ATTENDING PHYSICIAN

Has Child's Disability Existed Continuously Up To The Present? ☐ Yes ☐ No	Date Child's Disability Occurred	Child's I.D.	Prognosis (Estimate months or Years)	Is Child Now Incapable of Self-support Because of the Disability? ☐ Yes ☐ No

Nature of Disability (Please give as much detail as practicable) - Use other side of sheet if necessary.

Date

Signature of Physician

Physician's Address

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