of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
bcbst.com

Certification of Dependency

- Confidential -

Subscriber Name:_____ **ID No.:**_____ **Group No.:**_____

For purposes of establishing eligibility for dependent health care benefits, the undersigned certifies as follows:

1. Dependent Name: _____ Date of Birth: _____

2. Dependent Status:
   - ❑ Natural Child
   - ❑ Step-Child
   - ❑ Adopted Child ***(Please attach final decree or placement contract signed by the representing agency/judge)***
   - ❑ Legal Guardianship or Legal Custody ***(Please attach court order signed by the representing agency/judge)***
   - ❑ Other - Explain: _____

3. Dependent is:
   - A. ❑ Married ❑ Single ❑ Divorced ❑ Widowed
   - B. A full-time student ❑ Yes ❑ No
     If "Yes," list school name: _____ ***If "No," list date last attended:*** _____
   - C. Employed: Full-time: ❑ Yes ❑ No Part-time: ❑ Yes ❑ No
     If "Yes":
     How Long Employed: _____ No. Hours Worked Per Week: _____
     Monthly Earnings: $_____
     Name of Employer: _____
   - D. Residing full-time in your home? ❑ Yes ❑ No
     If "No," please give other residence and reason: _____
   - E. Receiving income or support from any other source? ❑ Yes ❑ No
     If "Yes," please indicate source and monthly amount: _____

4. If the dependent is employed or receives income from other sources, what ADDITIONAL support do you provide?
   I provide _____% of this dependent's support.

5. Has the dependent, at any time prior to meeting the age limit criteria established by the Employer, been incapable of self-sustaining employment due to an intellectual or physical disability? ❑ Yes ❑ No
   If "Yes," please have physician complete reverse side.

6. Is there a divorce decree ordering you to provide insurance or pay medical expenses for this dependent? ❑ Yes ❑ No
   If "Yes," please attach copy, including page bearing judge's signature denoting finalization.

_____ _____

Subscriber's Signature **Date**

(continued on reverse side)

Physician's Certification

I hereby certify that the dependent referred to on the reverse side of this form is:

❑ Incapable of self-sustaining employment due to physical disability.

Please provide brief description of disability.

_____

_____

Date of Onset: _____

❑ Incapable of self-sustaining employment due to intellectual disability.

Please provide brief description of disability.

_____

_____

Date of Onset: _____

_____ **M.D.** _____

Signature of Physician **Date**

_____

Name of Physician *(Please Print)*

_____

Address **City** **State** **ZIP Code**

Return To: BlueCross BlueShield of Tennessee
Membership Services Department
1 Cameron Hill Circle
Chattanooga, Tennessee 37402-0001