



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

# 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.**

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Date of Onset: \_\_\_\_\_

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

**Please provide brief description of disability.**

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Date of Onset: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Physician** **M.D.** \_\_\_\_\_  
**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**

BlueCross BlueShield of Tennessee

1 Cameron Hill Circle | Chattanooga, TN 37402 | bcbst.com

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For TDD/TTY help call 1-800-848-0298.

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-565-9140-1 (رقم هاتف الصم والبكم: 800-848-0298-1)

注意：如果r使用繁體中文，r可以免費獲得語言援助服務。請致電 1-800-565-9140 (TTY:1-800-848-0298)。