

Request to Continue Dependent Coverage



Your request cannot be processed if any information is missing.
Please fill in all sections on both pages completely and mail to:
Anthem Blue Cross

Section 1: Subscriber information

Last name		First name		M.I.	Member ID no.	
Street address			City		State	ZIP code
Phone no.		Employer name			Group no.	

Section 2: Dependent information

Last name		First name		M.I.	Date of birth (MMDDYYYY)	
Social Security no.		Gender Male Female	Marital status Married Single		Relationship to subscriber	
Type of impairment or injury					Date of impairment or injury	
Does the subscriber claim the dependent for income tax purposes? Yes No						
Does the dependent live with the subscriber? Yes No						
If no to either question, please explain: _____						

Section 3: Additional insurance policies for this dependent

Does the dependent have another health plan? Yes No						
Will your Anthem policy replace their other insurance? Yes No						
If yes to either question, complete the following.						
Other plan's policyholder name			Date of birth (MMDDYYYY)		Policy no.	
Health insurance company name			Other plan phone no.		Other plan group no.	
RX Bin		RX PCN		Date coverage started		Date coverage ended
How did they get these benefits? Through employer As individual Another way – describe: _____						
Is the dependent currently receiving Social Security benefits? Yes No						
If yes , what was the effective date? _____ If no , have benefits been denied? Yes No						

Medicare – Answer these questions if their other health plan is Medicare.

Name of Medicare cardholder	Medicare claim ID/no.	Effective dates for each part	Medicare entitlement reason
		A: _____ B: _____ C: _____	Age Disability ESRD*

*If ESRD (kidney or renal failure) is the primary reason for Medicare, provide the date of first dialysis treatment: _____
and transplant date if applicable: _____

Signature required

I certify that the above information is correct and authorize the release of medical information requested with respect to this certification.	
Signature of subscriber X	Date (MMDDYYYY)

Section 4: Diagnosis/Prognosis – Must be completed and certified by a physician.

Diagnosis		ICD-10 code(s)	
Describe the dependent's limitations in performing daily activities and ability to manage their affairs			
In your opinion, is the above named dependent currently incapable of self-sustained employment? Yes No			
In your opinion, will the dependent ever be capable of self-sustained employment? Yes No			
If "Yes," provide estimated date of return to full functionality: <input type="text"/> (MMDDYYYY)			
Physician name		Physician signature X	Date (MMDDYYYY)
Physician street address		City	State ZIP code