PREMERA HMO

DISABLED DEPENDENT CERTIFICATION

PLEASE READ CAREFULLY

The "Disabled Dependent Certification" form is used to determine if your adult dependent child meets the plan's eligibility requirements for continued coverage after the age limit is reached.

IMPORTANT NOTE
The inability to find employment or a reduction in work force is, of themselves, NOT evidence of eligibility for continuation of coverage.

INSTRUCTIONS

You or your physician may submit the information requested in this "Disabled Dependent Certification" form. Please complete all required sections and sign the attestation statement at the end.

Step 1: Complete all applicable sections of the Disabled Dependent Certification attached form.

Step 2: Subscriber must complete and sign the applicable fields.

Step 3: Licensed physician must complete and sign the applicable fields. (where applicable)

Step 4: Include ***one*** of the following information:

- Copy of the Social Security Disability Insurance* (SSDI) Award Letter (where applicable)
- Copy of the active Court Order (where applicable) example: Legal Guardianship
  - *If copy of SSDI OR Court Order are not available; the Physician's attestation must be completed, and signature required*
- Physician Attestation (where applicable)
  - If child has only SSI** and *not* SSDI*, the child's physician will need to complete section 3; the Physician's Statement.

Step 5: Send to:

Premera
Membership & Billing, MS 137
PO Box 91059
Seattle, WA 98111-9159

If you have any questions regarding the attached form please contact Customer Service at the number located on the back of your ID card.

CONDITIONS OF ELIGIBILITY
Under the provisions of the Contract coverage, a dependent who is mentally or physically disabled may continue coverage to any age provided the dependent is:

1. Dependent became disabled before reaching the limiting age (over the age of 25).
2. Dependent must be incapacitated or incapable of self-sustaining employment.
3. Dependent must be mentally or physically disabled prior to attainment of the age where coverage would otherwise be terminated.

Social Security Disability Insurance is the Federal Insurance Program
Supplemental Security Income (SSI) program pays benefits to disabled adults and children who have limited income and resources.

** The attending physician's statements regarding disability status are necessary and important for Premera; however, Premera is not bound by the physician's conclusion.

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ALL SECTIONS MUST BE COMPLETED PER INSTRUCTIONS (review carefully)

SECTION 1: SUBSCRIBER INFORMATION				
Full name of Subscriber: (last, first, middle)	Subscriber ID#:		Group #:	
Street Address:	City:	State:	Zip code:	Telephone No:

SECTION 2: DEPENDENT INFORMATION		
Full Name of disabled dependent: (last, first, middle)	Date of birth:	Relationship to Subscriber:
Marital Status: ☐ Married ☐ Single	Address: (if different than subscriber)	
Sex: ☐ Male ☐ Female	Nature of disability:	Date of disability:
Does dependent currently have other/additional health insurance? (example: Medicare) ☐ Yes ☐ No If Yes, provide responses in the fields below.		
Other/Additional Health Insurance Name:	Other Health Insurance ID Number:	Customer Service Number:
Is the Other Health Insurance company *Primary* coverage for the dependent? ☐ Yes ☐ No		

SOCIAL SECURITY DISABILITY OR LEGAL GUARDIANSHIP SUPPORTING DOCUMENTS

Has the dependent been declared disabled by the Social Security Administration?

☐ If **Yes**, (attach SSDI *and SSI** document)
☐ If **No**, provide subscriber signature below and then continue to section 3

If **yes**, complete the following:

- Copy of the SSDI* Award letter
- Most recent monthly SSI** statement
  and/or
- Applicable court order
- Sign on the Subscriber signature line and **STOP**

If **no**, provide subscriber signature and then continue to section 3.

Subscriber Signature:

_____

OR

Has the dependent been placed in Legal Guardianship by a court order?

☐ If **Yes,** (attach active court order)
☐ If **No**, provide subscriber signature below and then continue to section 3

If **yes**, complete the following:

- Attach the copy of the active Legal Guardianship court order
- Sign on the Subscriber signature line and **STOP**

If **no**, provide subscriber signature below and then continue to section 3.

Subscriber Signature:

_____

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SUBSCRIBER SIGNATURE – must be signed for the form to be valid
Please note: it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. I certify/attest that <Dependent's Name> meets the following criteria: 1. The dependent became disabled before reaching the limiting age; and 2. Is incapable of self-sustaining employment due to disability; and 3. The dependent relies primarily upon Subscriber (and/or spouse) for support and maintenance. Subscriber's Signature _____ Date of Signature _____ *(My signature attests that the above statements are true and if requested I can provide further substantiating documentation.)*

SECTION 3: PHYSICIAN'S INFORMATION – the following must be completed, signed and certified by a physician IMPORTANT NOTE The inability to find employment or a reduction in work force is, of themselves, NOT evidence of eligibility for continuation of coverage		
Provider Name:	Provider Mailing Address:	Provider Contact Phone: Fax Number:
Date of Patient's last exam: (The application date and date of the last exam must be Must be within the past year)	Disability is Complete 100% ☐ Yes ☐ No	Disability is: Partial ____%
Is this disability temporary or permanent? ☐ Temporary ☐ Permanent		If temporary, estimated duration:
Diagnosis causing disability: (provide ICD-10 and standard nomenclature of condition)		
Will dependent/patient be capable of self-support ☐ Yes ☐ No. If yes, when (date)		
Please note: it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. Signature of Attending Physician (Print / Credentials): _____ Date of Signature: _____ *(My signature attests that the above statements are true and if requested I can provide further substantiating documentation.)*		

** The attending physician's statements regarding disability status are necessary and important for Premera; however, Premera is not bound by the physician's conclusion.

PREMERA HMO

Discrimination is Against the Law

Premera Blue Cross HMO (Premera HMO) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera HMO does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera HMO provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera HMO provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera HMO has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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 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 Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 844-722-4661 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 844-722-4661（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 844-722-4661 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 844-722-4661 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 844-722-4661 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 844-722-4661 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 844-722-4661 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 844-722-4661 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。844-722-4661（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 844-722-4661 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 844-722-4661 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 844-722-4661 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 844-722-4661 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 844-722-4661 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 844-722-4661 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 844-722-4661 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 844-722-4661 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 844-722-4661 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 844-722-4661 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 844-722-4661 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 844-722-4661 (TTY: 711) تماس بگیرید.