



# Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Please return the completed form.

By Mail: PO Box 1271 MS5C  
Portland, OR 97207-1271  
By Fax: 1 (866) 303-5117

## Affidavit of Qualifying Incapacitated Dependent Eligibility

### SECTION 1 - STATEMENT OF DEPENDENT'S ELIGIBILITY (to be completed by the Employee)

Employee's Name			ID Number
Employee's Address		City	State ZIP Code
Group Number			Dependent's Birthdate
Dependent's Name			Dependent's Marital Status
Dependent's Relationship to Employee			Dependent's Marital Status
Dependent's Address (if not residing with Employee)		City	State ZIP Code
Please explain why dependent does not reside with employee.			
Is dependent currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Employment Began _____	
Position Held _____		Average Hours Worked Per Week _____	
Dependent's Current Employer's Name			
Current Employer's Address		City	State ZIP Code
Was dependent previously employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dates of Employment _____ to _____	
Position Held _____		Average Hours Worked Per Week _____	
Dependent's Previous Employer's Name			
Dependent's Previous Employer's Address		City	State ZIP Code
Does dependent have other health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the name of the carrier, Employee name, policy number and carrier's phone number:			
Is the dependent eligible for or have Medicare coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the type of coverage, effective date and the Medicare Number (please include the alpha prefix):			
Has the dependent been declared disabled by the Social Security Administration? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the date of acceptance? _____ (please attach a copy of the SSI acceptance letter)			
What is the dependent's estimated gross monthly income from all sources \$ _____		What is the percentage of dependent's financial support supplied by Employee _____ %	
I certify that _____, meets the following criteria: Name of incapacitated dependent (please print)			
<ol style="list-style-type: none"> <li>1) Has been continuously covered by health insurance as my dependent with no break in coverage of more than 63 days;</li> <li>2) Is incapable of self-sustaining employment due to incapacitation related to developmental disability, medical disability, and/or mental disorder; and</li> <li>3) Is significantly dependent upon Employee (and/or Employee's spouse) for support and maintenance.</li> </ol>			
Signature of Employee			Date

