Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

HEALTH ADVANTAGE

Proof of Incapacity of a Dependent

THIS FORM MUST BE SUBMITTED TO HEALTH ADVANTAGE

To Be Completed by Subscriber

Subscriber Name_____ Subscriber ID#_____

Subscriber SSN_____ Home Phone_____

Address_____ Work Phone_____

Group Name_____ **Group Number**_____

Dependent Name_____ Dependent SSN_____

Sex: ☐ Male ☐ Female Date of Birth _____ Relationship to Subscriber_____

Primary Care Physician _____

Date disability began_____ Percent of Financial Support by Subscriber_____

Last Grade Completed: 8 9 10 11 12 Special education classes ___yes ___no College 1 2 3 4

Dependent is Student ☐ Yes ☐ No Attends Special Program ☐ Yes ☐ No

Name/address of school/program_____

Indicate which activities dependent perform or not perform without assistance

Yes	No	
		Dress self
		Bathe
		Walk
		Cook meals
		Housework
		Manage medications

Yes	No	
		Manage finances
		Drive
		Attend School
		Be employed
		Use a computer
		Shop for food/necessities

Is dependent certified as disabled by Social Security Administration? ☐ Yes ☐ No

Is dependent covered by any other health insurance including Medicare or Medicaid? ☐ Yes ☐ No

If Yes, give policy numbers, effective date, name and address of other insurance company, and name in which policy is held:_____

I certify that the above information is true and correct and that the dependent listed above is, by reason of mental retardation or physical handicap, residing with me and solely dependent upon me for financial support and maintenance. (A copy of most recent Federal Income Tax return may be requested)

Subscriber Signature Date

Group Administrator Signature (if new member) Date

Please have the attached form completed by the Dependent's physician. Submit both forms:

Mail: Health Advantage Membership
P.O. Box 8069
Little Rock, AR 72203-8069

For Health Advantage Use Only

Approved_____ Date_____

Annual Reverification required ☐ Yes ☐ No

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Proof of Incapacity of a Dependent

Must Be Completed by the Physician

Subscriber Name_____Subscriber#_____

Address_____

Dependent Name_____

Health Advantage covers dependent children that have reached the maximum dependent age that are physically or mentally incapacitated and incapable of self-support. In order for Health Advantage to make a determination, the following information must be completed. Please attach any supporting documentation.

Current age_____ Height_____ Weight_____

Mental Incapacity_____ Physical Incapacity _____ Age at onset of condition/disability_____

Describe Incapacity or reason incapable of self care/self support_____

_____

_____

Acute medical conditions (describe) _____

_____

Chronic medical conditions (describe) _____

_____

Future health concerns or considerations_____

_____

Medications, dosage, reason for medication _____

_____

Other important facts_____

_____

A copy of any pertinent medical information may be attached.

I have examined the dependent named above, and the degree of his/her disability or incapacity is of such a nature that he/she is incapable of self care/self support.

Physician Name	Specialty
Physician Signature	Date

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE NOTICE

NOTICE: Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and 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 our Civil Rights Coordinator.**

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276; TDD: 1-844-662-2275

You can file a grievance in person, by mail, or by email. If you need help filing a grievance our 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 Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-844-662-2276.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276.

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 1-844-662-2276.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-662-2276 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-662-2276.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-662-2276.

ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. إتصل بالرقم 1-844-662-2276.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-662-2276.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-662-2276.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-662-2276.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-662-2276.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-662-2276.

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。1-844-662-2276 まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-662-2276.

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات و کمک‌های زبانی رایگان برای شما موجود است. برای کسب اطلاعات بیشتر، با شماره 1-844-662-2276 تماس بگیرید.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-662-2276.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-662-2276 पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-662-2276.

انتباہ: اگر آپ اردو بولتے ہیں تو، آپ کے لئے زبان کی مدد کی خدمات بلا معاوضہ دستیاب ہیں۔ 1-844-662-2276 پر کال کریں۔

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-662-2276.

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-844-662-2276.