

Please complete online, print form and mail to the address on the next page. Keep a copy of the completed form for your records.

Section A: Subscriber information				
Name		Contract number		
Birth date	Martial status <input type="checkbox"/> Single <input type="checkbox"/> Married		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Primary residence: Street address		City	County	State Zip code
Other residence (if any): Street address		City	County	State Zip code
Home telephone number		Day telephone number		

Section B: Dependent information			
Please list your incapacitated dependent.			
First name		Last name	
Relationship		Social security number	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Birth date	Date condition developed MM/DD/YY
Diagnosis			

Please provide supportive documentation on dependent's condition. Documentation must be signed by the physician and on physician letterhead. Attach and submit documentation with this form.

Section C: Medicare information
Is the dependent entitled to Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section D: Other insurance			
Is the dependent currently covered by health insurance other than this BCBSM plan or Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please complete below.			
Name of insured	Insurance company name		
Insurance company address: Street/P.O. Box number	City	State	Zip code
Group or policy number	Contract type <input type="checkbox"/> Single <input type="checkbox"/> Family	Policy effective date MM/DD/YY	

Section E: Additional information

Section F: Verification
I certify that I have carefully and fully read the important information on the next page of this form. I also certify that the statements and answers given are complete and correct to the best of my knowledge and belief. No information required to be given, either expressly or by implication, has been knowingly withheld. I have provided supportive documentation on my dependent's disability as requested above and am aware that without proper documentation coverage may be denied. I am also aware that additional information may be required to make a determination of coverage and that presenting this documentation does not imply automatic coverage.

Subscriber's signature (do not print)

Date signed

Continuing coverage for incapacitated children

Incapacitated children are those who are unable to earn a living because of mental retardation or physical disability and must depend on their parents for support and maintenance.

If your enrolled dependent is an incapacitated child, your coverage for this child will continue beyond age 19 as long as he or she became incapacitated before age 19, continues to be incapacitated and your coverage does not terminate for any other reason.

To ensure uninterrupted coverage for your incapacitated child, you must apply for continuation within 31 days after the child turns 19.

If your dependent meets these guidelines, your physician must provide medical documentation on the physician's office stationary signed by the physician and include the following information:

- The specific nature of the disability
- Signs and symptoms associated with the disability
- The date such disability commenced
- Attending physician's recommendation for job rehabilitation and gainful employment

Upon receipt of the above documentation, we will review and determine if your dependent qualifies for continued health coverage as incapacitated. If your dependent does not meet the guidelines as stated above under Public Act 350 for incapacitated dependents, your dependent is not eligible to remain on your health care insurance and will be removed.

Forward the requested information and the completed application form to:

Blue Cross Blue Shield of Michigan
Key State Accounts - State of Michigan Marketing Unit
600 E. Lafayette Blvd.
Detroit, MI 48226
ATTN: Senior Medical Analyst – MC 517J

If you have any questions, please call the BCBSM State of Michigan Service Center at 800-843-4876.