



of Tennessee

1 Cameron Hill Circle
Chattanooga, TN 37402
bcbst.com

Certification of Dependency

- Confidential -

Subscriber Name: _____ ID No.: _____ Group No.: _____

For purposes of establishing eligibility for dependent health care benefits, the undersigned certifies as follows:

1. Dependent Name: _____ Date of Birth: _____

2. Dependent Status:

- Natural Child
- Step-Child
- Adopted Child **(Please attach final decree or placement contract signed by the representing agency/judge)**
- Legal Guardianship or Legal Custody **(Please attach court order signed by the representing agency/judge)**
- Other - Explain: _____

3. Dependent is:

A. Married Single Divorced Widowed

B. A full-time student Yes No

If "Yes," list school name: _____ **If "No," list date last attended:** _____

C. Employed: Full-time: Yes No Part-time: Yes No

If "Yes":

How Long Employed: _____ No. Hours Worked Per Week: _____

Monthly Earnings: \$ _____

Name of Employer: _____

D. Residing full-time in your home? Yes No

If "No," please give other residence and reason: _____

E. Receiving income or support from any other source? Yes No

If "Yes," please indicate source and monthly amount: _____

4. If the dependent is employed or receives income from other sources, what ADDITIONAL support do you provide?
I provide _____ % of this dependent's support.

5. Has the dependent, at any time prior to meeting the age limit criteria established by the Employer, been incapable of self-sustaining employment due to an intellectual or physical disability? Yes No

If "Yes," please have physician complete reverse side.

6. Is there a divorce decree ordering you to provide insurance or pay medical expenses for this dependent? Yes No

If "Yes," please attach copy, including page bearing judge's signature denoting finalization.

Subscriber's Signature

Date

Physician's Certification

I hereby certify that the dependent referred to on the reverse side of this form is:

- Incapable of self-sustaining employment due to physical disability.

Please provide brief description of disability.

Date of Onset: _____

- Incapable of self-sustaining employment due to intellectual disability.

Please provide brief description of disability.

Date of Onset: _____

Signature of Physician **M.D.** _____
Date

Name of Physician (Please Print)

Address **City** **State** **ZIP Code**

**Return To: BlueCross BlueShield of Tennessee
Membership Services Department
1 Cameron Hill Circle
Chattanooga, Tennessee 37402-0001**

BlueCross BlueShield of Tennessee

1 Cameron Hill Circle | Chattanooga, TN 37402 | bcbst.com

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For TDD/TTY help call 1-800-848-0298.

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-565-9140-1 (رقم هاتف الصم والبكم: 800-848-0298-1)

注意：如果r使用繁體中文，r可以免費獲得語言援助服務。請致電 1-800-565-9140 (TTY:1-800-848-0298)。