



An Anthem Company



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THIS SECTION MUST BE COMPLETED

Subscriber Member Number

Grid for Subscriber Member Number (12 boxes)

Health Group Number

Grid for Health Group Number (10 boxes)

Dental/Vision Group Number

Grid for Dental/Vision Group Number (10 boxes)

Mentally or Physically Disabled Dependent Enrollment Request

Check coverage(s) that apply(ies): Health Dental Vision

TO BE COMPLETED BY DEPENDENT'S PARENT OR LEGAL GUARDIAN

Subscriber Name (First, Middle Initial, Last)

Grid for Subscriber Name (24 boxes)

Home Address (Street)

Grid for Home Address (24 boxes)

City

Grid for City (16 boxes)

State

Grid for State (2 boxes)

Zip

Grid for Zip (5 boxes)

Dependent Name (First, Middle Initial, Last)

Grid for Dependent Name (24 boxes)

Dependent Birthdate (MM-DD-YYYY)

Grid for Dependent Birthdate (8 boxes)

Dependent Marital Status

Single Married Widowed Divorced

Was the dependent ever institutionalized? NO YES, give name and address of institution and period(s) of confinement

Is the dependent eligible for care or coverage under Federal, State or Local Law? NO YES, give details

Is, or was, the dependent employed for wages? NO YES, give name and address of current or last employer and average weekly earnings

If the dependent is no longer employed, give reason for termination

Is the dependent financially dependent on the subscriber? NO YES

SUBSCRIBER SIGNATURE

DATE

TO BE COMPLETED BY DEPENDENT'S PHYSICIAN ONLY

Dependent is presently incapable of self-sustaining employment by reason of: Mental Disability Physical Disability

Is the disability congenital? YES NO

In your opinion, will dependent ever be capable of self-sustaining employment YES NO

Diagnosis of condition causing disability status

Remarks (Provide as much detailed information that you believe may be beneficial in this matter. Attach additional documentation as applicable.)

Physician's Name

Physician's Address (Street, City, State, Zip Code)

PHYSICIAN SIGNATURE

DATE

ATTENDING PHYSICIAN

Please submit completed form to: Anthem Blue Cross and Blue Shield – 700 Broadway – 01W0965 – Denver, Colorado 80273

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages.

ANTHEM BLUE CROSS AND BLUE SHIELD / HMO COLORADO / HMO NEVADA USE ONLY

Approved as being (a) Permanently disabled (No re-certification necessary)
(b) Disabled, re-certification is necessary. Re-certification date: _____

Not Approved as a disabled dependent

BY

DATE

COLORADO AND NEVADA