of Tennessee
plans for better health. plans for a better life.®

1 Cameron Hill Circle
Chattanooga, Tennessee 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-support due to physical handicap or mental retardation? ☐ 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**

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

(continued on reverse side)

Physician's Certification

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

- ☐ Permanently disabled due to physical handicap and is unable to be gainfully employed.

  Please provide brief description of disability:

  ____

  ____

  Date of Onset: ______________________________

- ☐ Mentally Retarded.

  Please provide degree or extent of retardation:

  ____

  ____

  Date of Onset: ______________________________

______________________________ **M.D.** ______________________________

Signature of Physician **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