



**of Tennessee**

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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

# 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:*

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Date of Onset: \_\_\_\_\_

- Mentally Retarded.

*Please provide degree or extent of retardation:*

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Date of Onset: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Physician** **M.D.** **Date**

\_\_\_\_\_  
**Name of Physician (Please Print)**

\_\_\_\_\_  
**Address** **City** **State** **ZIP Code**

You cannot digitally sign this form, please print to sign.

**Return To: Tusculum College  
Human Resources  
P.O. Box 5093  
Greeneville, TN 37743  
or by email to  
tcbenefits@tusculum.edu**