Horizon Blue Cross Blue Shield of New Jersey

P.O. BOX 607 DEPT. A
NEWARK, NEW JERSEY 07101-0607

**IMPORTANT:** READ INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS PRIOR TO COMPLETING ATTACHED FORM

## INSTRUCTIONS TO SUBSCRIBER

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1. Read the ELIGIBILITY REQUIREMENTS below.
2. Provide the information requested in boxes 1 through 28 of PART I.
3. Read the conditions contained in PART I, sign and date where indicated.
4. Forward the form to the dependent's attending Practitioner.

## INSTRUCTIONS TO THE PRACTITIONER

1. Provided all information requested in PART II.
2. Forward the completed form to:

   HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY, INC.
   P.O. BOX 607 DEPT. A
   NEWARK, NEW JERSEY 07101-0607

## CONDITIONS NECESSARY TO ESTABLISH ELIGIBILITY

1. The dependent is unmarried
2. The incapacitating condition started before the age specified policy age limit.
3. The dependent must have been insured before the age limit of the policy. If insured by another carrier before applying to Horizon BCBSNJ, documentation should be provided.
4. The application for continuation of enrollment must be filed within 31 days from the date the dependent reaches policy age limit.
5. The subscriber must provide proof of the dependent's incapacitation by submitting responses to the following questions at the time of application for continuation of enrollment.
6. Frequency for reassessment of continuation determined by dependent's condition and contract requirements.

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# Request For Continuance of Enrollment For a Disabled Dependent

You may complete the required fields below online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.

## PART I - TO BE COMPLETED BY SUBSCRIBER

| 1. SUBSCRIBER'S NAME | 2. TELEPHONE # ( ) - | 3. SOCIAL SECURITY NO. |
|---|---|---|

| 4. ADDRESS | Street | City | State | Zip |
|---|---|---|---|---|

| 5. DEPENDENT'S NAME | 6. RELATIONSHIP TO SUBSCRIBER | 7. DEPENDENT'S BIRTH DATE | 8. DATE OF ONSET OF DISABILITY / HANDICAP |
|---|---|---|---|

| 9. NAME OF PRESENT INSURANCE CARRIER FOR DEPENDENT | 10. ID # / POLICY # |
|---|---|

| 11. GROUP # | 12. COVERAGE START DATE | 13. COVERAGE END DATE |
|---|---|---|

| 14. Please indicate prior insurance carrier since onset of disability / handicap<br>CARRIER NAME | 15. ID # / POLICY # |
|---|---|

| 16. GROUP # | 17. COVERAGE START DATE | 18. COVERAGE END DATE | *Attach any additional information on separate page* |
|---|---|---|---|

19. WHY ARE YOU APPLYING FOR CONTINUATION OF BENEFITS FOR THE DEPENDENT AT THIS TIME?

20. CAN THE DEPENDENT PERFORM ACTIVITIES OF DAILY LIVING (ADL - e.g. bathing, dressing, eating)?
☐ YES ☐ NO If NO, please explain:

21. IS THE DEPENDENT CAPABLE OF TRAVELING TO AND FROM A DESTINATION UNATTENDED?
☐ YES ☐ NO

22. DOES THE DEPENDENT WORK FOR WAGES?
☐ YES If YES, give name of employer:
☐ NO If NO, give reason(s) why unable to work:

23. IS DEPENDENT ELIGIBLE FOR HEALTH COVERAGE THROUGH HIS, HER EMPLOYER?
☐ YES ☐ NO

24. IS DEPENDENT IN COLLEGE / SPECIAL SCHOOL OR CONFINED TO AN INSTITUTION?
☐ YES ☐ NO If YES, give name/location: Type of program or course of study:

25. DOES THE DEPENDENT RECEIVE OR HAS THE DEPENDENT EVER RECEIVED VOCATIONAL TRAINING DESIGNED TO INCREASE INDIVIDUAL FUNCTIONALITY?
If so name: If not, why not:
dates:

26. WHAT ARE THE SPECIFIC WAYS IN WHICH YOU SUPPORT OR MAINTAIN THE DEPENDENT?

27. HOW / WHAT TYPE OF CARE DO YOU PROVIDE FOR THE DEPENDENT?

28. HAS THE DEPENDENT APPLIED FOR SSI / MEDICARE / MEDICAID? (circle all applicable)
If not, why:

In accordance with amendments to the New Jersey laws governing health service corporations whereby the enrollment of mentally impaired and/or physically disabled children who attained termination age on and after August 10, 1966 may, under certain conditions, be continued under their parent's Horizon Blue Cross Blue Shield of New Jersey, Inc. coverage beyond such termination age, I herewith request such continuation of enrollment on behalf of my child named above.

I UNDERSTAND AND AGREE that continuation of enrollment for the child named above, if approved, may remain in effect only as long as the mental impairment and/or physical disability and dependency exist, and so long as Horizon Blue Cross Blue Shield of New Jersey, Inc. coverage, in my name or in the name of my spouse, if any, remains in force, with no greater than thirty day lapse between any changes in coverage, and provided that coverage is at all times of the type which includes such child. I FURTHER UNDERSTAND AND AGREE that the Plan shall have the right to require periodic recertification as to eligibility for continued extension of dependency coverage.

I represent that to the best of my knowledge and belief the information given above is correct, that the child named above meets the eligibility requirements as to unmarried status and enrollment under my coverage, and is dependent upon me for more than one-half of his(her) support and maintenance.

*Subscriber's Name:* ______________________________ *Date:* ____/____/____



Independent Licensee of Blue Cross Blue Shield of New Jersey

## PART II - TO BE COMPLETED BY DEPENDENT'S ATTENDING PHYSICIAN

*Questions to be answered by the dependent's Attending Practitioner:*
*(If disability is due to mental or psychiatric disorder, please have the appropriate behavioral health provider complete form).*

1. Specific diagnosis(s) (Use ICD9 or DSMS codes as applicable.) ______________________________

2. If mentally impaired, define mental impairment in terms of mental age __________ IQ __________ or functional capacity in work, educational or social setting. *Please attach results or summary of most recent testing done to define dependent's functional level.*

3. If physically impaired, define physical impairment in terms of capacity to perform activities normally done by individuals of comparable age, intellectual capacity.

4. Is the condition temporary or permanent? ______________________ Is the condition static or progressive? ______________________

5. Is the condition currently controlled with medical management? If No, why not ______________________

   If Yes, specify therapy ______________________

6. If dependent is attending college, working, or in a training program, what makes this individual more reliant on parent support and maintenance than his/hers non disabled peers and thus make continuation of enrollment under parent's policy necessary.

   ______________________________

7. In your opinion, is the dependent able to work, attend school or a vocational training program? Now: ☐ Yes ☐ No In the Future: ☐ Yes ☐ No

   If no, why not?

I hereby certify that I am a practicing ______________________ duly licensed in the State of ______________________ and certify to the correctness of this information provided above.

| *Please print the following information* | PRACTITIONER'S NAME |
|---|---|
| | PRACTITIONER'S ADDRESS |

| SIGNATURE OF PRACTITIONER | PHONE # ( ) - | DATE SIGNED |
|---|---|---|

## PART III - TO BE COMPLETED BY PLAN

Continuation of enrollment of the dependent named above under his(her) parent's coverage (is) (is not) approved. This certification applies to all coverages.

Authorized Signature: ______________________________ Date: ______/______/______