HANDICAPPED / DISABLED MEMBER CERTIFICATION

Check one:
☐ BCBSGA ☐ NASCO
☐ BCBSHP

DCN

Full Name of Contract Holder (Last, First, Middle)	Group Number	Contract Number

Mailing Address	City	State	Zip Code	Telephone Number

Full name of handicapped/disabled applicant (Last, First, Middle)	Birthdate	Sex	Social Security No. of Applicant
		☐ Male ☐ Female	

Marital Status	Relationship To Contract Holder	Nature of Disability	Date of Disability
☐ Married ☐ Single			

Is applicant listed as Income Tax exemption? ☐ Yes ☐ No

Was or is applicant employed for wages? ☐ Yes ☐ No

Name of last Employer	Address of last Employer (Street, City, State, Zip Code)	Average Weekly Earnings

Reason for Termination	Termination Date	Does applicant now have any Hospital/Medical coverage? If "Yes", complete details below. ☐ Yes ☐ No

OTHER COMPANIES WITH WHICH YOU HAVE INSURANCE POLICIES PROVIDING FOR DISABILITY, SICKNESS OR ACCIDENT BENEFITS

Company	Address(Street, City, State, Zip Code)	Policy or Certificate Number

Is applicant eligible for care under Federal, Sate or Local Law? ☐ Yes ☐ No	If "Yes", give type of care	Address of agency providing care (Street, City, State, Zip Code)

Is applicant currently receiving Social Security benefits? ☐ Yes ☐ No	If "Yes", what was the effective date?	If "No", have benefits been denied? ☐ Yes ☐ No

THE FOLLOWING MUST BE COMPLETED AND CERTIFIED BY A PHYSICIAN

1. The above named applicant is presently incapable of self-sustaining employment by reason of (Check One)
☐ Mental Handicap ☐ Physical Handicap ☐ Total Disability

Is handicap congenital? ☐ Yes ☐ No

2. Diagnosis of condition(s), illness or injury causing status checked in Number 1 above (Describe fully the nature of the disability)

Date of Disability Mo. / Day / Year

3. Prognosis and estimated number of months or years

4. Was applicant hospital confined? ☐ Yes ☐ No	Name of hospital, if admitted an an inpatient

Admitted (Mo., Day, Year)	Discharged (Mo., Day, Year)	Address of hospital (Street, City, State, Zip Code)

Admitting Diagnosis

Date applicant became totally and continuously disabled and wholly prevented from engaging in any occupation whatsoever for compensation — Mo. / Day / Year

Has applicant been able to engage in any gainful occupation or do any work since the disability began? ☐ Yes ☐ No	Date applicant resumed work or expects to resume work — Mo. / Day / Year

PHYSICIANS CONSULTED SINCE DISABILITY BEGAN	ADDRESS	DATES CONSULTED FROM	DATES CONSULTED TO

Name of Attending/Admitting Physician	Signature of Physician certifying above information	Date Signed

I agree that any coverage which may be issued to the dependent named hereon shall be binding only if all statements in this certification are complete and true, and if approved by the Blue Cross and Blue Shield of Georgia Plan. Furthermore, the Plan may declare ineffective the applicant coverage if any statement is not complete and true.

I, the undersigned, hereby certify that the above statements are each and all complete and true to the best of my information knowledge and belief, and that they are made for the purpose of securing the disability benefits set forth in the disability provision contained in the above described policy or policies. I agree that these statements and the statements of all physicians who attended or treated the insured shall constitute the basis of this claim, and further agree that the furnishing of this form or any other forms supplemental thereto by Blue Cross and Blue Shield of Georgia (the Plan) shall not be considered an admission by it of any liability, nor a waiver of any of its rights or defenses.

The undersigned hereby waives on behalf of himself or of any person who shall be interested in the policies hereinbefore mentioned, all provision of law forbidding or restricting any physician or other person who, at any time, attended or examined the insured form disclosing in the courts or otherwise, any knowledge, information or belief which he thereby acquired, and I hereby specifically authorize all such persons, including hospitals, to freely communicate their knowledge to the Plan, if it requests them to do so.

SIGNATURE (If signed by anyone other than the insured, explain on reverse side) _____ DATE / / _____ WITNESS

Please read the conditions of eligibility and instructions on reverse side of this form

PLEASE READ CAREFULLY

CONDITIONS OF ELIGIBILITY

Under the provisions of the Contract's coverage, an applicant and/or applicants who are mentally or physically disabled may continue coverage to any age provided the applicant is

1. **Unmarried, and**
2. **So incapacitated as to be incapable of self-sustaining employment, and**
3. **Mentally or physically incapacitated prior to attainment of the age coverage would otherwise be terminated**

IMPORTANT POINTS:

Neither a reduction in work capability, nor inability to find employment, are, of themselves, evidence of eligibility for continuation of coverage.

If a mentally or permanently physically handicapped dependent is working despite his disability, the extent of his earning capacity will be evaluated.

Blue Cross and Blue Shield contract benefits will not be provided when such benefits are available in whole or in part, under the laws of the United States of America or any state or political subdivision thereof.

INSTRUCTIONS

We want to complete processing on your claim at the earliest possible date. In order to avoid delay, please read and follow the instructions printed below.

I. APPLICATION (SEE REVERSE SIDE)

A. Please answer all questions fully. If you do not have sufficient space, you may attach a separate sheet.

B. If you are self-employed, please attach a separate sheet indicating the present status of your business (i.e. sold, leased, liquidated, etc.)

II. ATTENDING PHYSICIAN'S STATEMENT

A. It is imperative that we have complete medical proof of your disability. This should be supplied by the physician(s) who treated you during the **entire** period of disability. If additional space is needed, please attach a separate sheet or complete office records.

B. Please ask your physician to answer **all** questions fully and to give **exact** dates. If any changes and/or corrections are necessary, please assure that each is initialed by the physician.

BLUE CROSS AND BLUE SHIELD OF GEORGIA

P.O. BOX 4445 **ATLANTA, GEORGIA 30302**