**Application for Continuing Coverage DUE MM/DD/YY**

**Who is the main person, or subscriber, on the policy?**

|  |
| --- |
| **Name (First, MI, Name) ID Number Group Number (if shown on ID Card)**  **Address (City, State, ZIP) Employer**  373780 |

**Who is the dependent child?**

|  |
| --- |
| **Name (First, MI, Name) Gender Date of Birth**  **Relationship to subscriber Marital Status**  **■ Single ■ Married ■ Divorced ■ Widowed** |

**Is dependent mentally or physically disabled? (To be completed by subscriber)**

|  |
| --- |
| ***If Yes:* Date disability occurred**  /  /  **Is child dependent on you for support?**  No  Yes  ***If Yes, what part of support do you contribute? %***  **Is child permanently living at your household?**  No  Yes  ***If No, explain***  No  Yes  **Was child identified as dependent on your last income tax return?**  **Is the child employed now? Or was the child ever employed?**  No  Yes  ***If Yes, employer name/address***  ***and dates employed***  **If not enrolled now, will he or she be enrolled as full-time student in**  No  Yes  **recognized course of study or training?**  ***If Yes, name of school***  **Is dependent eligible for other care under federal, state or local law?**  No  Yes  ***If Yes, explain*** |
|
|
|
|
|

**Is dependent approved for Social Security, SSI (Social Security income), and/or Medicare?**

* **No Physician must fill out next page before returning to us**
* **Yes Please attach proof of Federal coverage (such as copy of Medicare card or SS form with notification of payment). A physician does not need to fill out the next page.**

I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge. I hereby authorize any physician or other person who has attended my above named dependent child or who may hereafter attend or examine such child to disclose any knowledge or information thereby acquired by him to the plan stated above.

ID number

Date

Subscriber Signature

****Return within 30 days****

****By Fax:** 877-665-6394 **By Mail:** Anthem Blue Cross and Blue Shield**

**6740 North High Street**

**Worthington, OH 43085**

**Attn: National Enrollment**

****This section to be completed by dependent’s doctor****

**(unless dependent approved for social security, SSI, and/or Medicare)**

|  |
| --- |
| **Date disability occurred Prognosis (months or years)**  /  /  No  Yes  **Has child’s disability existed continuously up to the present**  No  Yes  **Is the child now incapable of self-support because of the disability**  **Nature of disability (please give as many details as possible, including any applicable diagnosis codes)** |

Date

Office Stamp

Doctor Signature

Doctor Address

]

****Return within 30 days****

****By Fax:** 877-665-6394 **By Mail:** Anthem Blue Cross and Blue Shield**

**6740 North High Street**

**Worthington, OH 43085**

**Attn: National Enrollment**

**Get help in your language**

**Curious to know what all this says? We would be too. Here’s the English version:**

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

**Spanish**

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda**.** (TTY/TDD: 711)

**Chinese**

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

**Vietnamese**

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

**Korean**

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

**Tagalog**

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

**Russian**

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

**Arabic**

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة.  
(TTY/TDD: 711)

**Armenian**

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

**Farsi**

شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

**French**

Vous avez le droit d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d’identification. (TTY/TDD: 711)

**Japanese**

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

**Haitian**

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

**Italian**

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

**Polish**

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

**Punjabi**

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

**It’s important we treat you fairly**

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services?   
Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>*.*