BlueCross BlueShield of Kansas
In Independent Licensee of the Blue Cross and Blue Shield Association.

APPLICATION FOR COVERAGE OF HANDICAPPED DEPENDENT CHILD

I. TO BE COMPLETED BY THE INSURED:

1. Insured's Name _____ Identification No. _____
2. Insured's Address _____
3. Name of Handicapped Dependent _____ SS#: _____
4. Dependent's Address _____
5. Dependent's Birth Date _____ ***Relationship to Insured*** _____
6. Is Dependent Married? ___Yes ___No
7. Are you responsible for the chief support and maintenance of the dependent child:
   ___Yes ___No
8. Is dependent an established beneficiary under Medicare or receiving SSA/SSI disability benefits?
   ___Yes ___No
   (If yes, ***only complete Section I, Questions 1 - 13*** and send in verification.)
9. Has the dependent had any income during the past year? ___Yes ___No
   If yes, please state the source of income _____and the amount _____.
10. Is the dependent attending school? ___Yes ___No
    If yes, name of school: _____
    Number of hours enrolled: _____
11. Physician's name (please print) _____
12. List other members of the health care team, i.e., specialist in rehab or mental health care.
    _____ _____
    _____ _____
13. Signature of insured: _____ Date: _____

II. TO BE COMPLETED BY THE ATTENDING PHYSICIAN:

1. Diagnosis of condition causing disability; indicate degree of severity _____
   _____
   _____
   _____
2. Prognosis (estimate in months or years) _____
   _____
3. Is dependent INCAPABLE of self support by reason of mental or physical disability?
   ___Yes ___No
4. Is dependent now confined in an institution? ___Yes ___No
   If yes, name of institution _____
5. Address of physician _____
6. Signature of physician _____ Date _____

Complete and Return to: Blue Cross and Blue Shield of Kansas
1133 SW Topeka Blvd.
Topeka, KS 66629-0001