Commonwealth of Virginia
Adult Incapacitated Dependent Certification Form

Anthem BlueCross BlueShield

Important Notice: To request continued coverage for your dependent child as an adult incapacitated dependent (AID) under the Commonwealth of Virginia Health Benefits Program, you must complete Part A of the adult incapacitated dependent form. Your dependent's physician must complete Part B of the form. Upon completion, the form must be returned to Barbara Muse, Anthem Blue Cross and Blue Shield, Commonwealth of Virginia Member Services, P. O. Box 27401, Maildrop VA2003-N155, Richmond, VA 23279, or fax to 804-354-4775.

If the form is not received by the end of the calendar year, coverage will end for your dependent January 1st of the following year.

Please feel free to contact Anthem Member Services at 1-800-552-2682 if you have questions.

Section 1: Employee/Retiree

Last name	First name	M.I.	ID no.

Street address	City	State	ZIP code

Phone no.	

Section 2: Adult Incapacitated Dependent (AID)

Last name	First name	M.I.	Date of birth (MM/DD/YYYY)

Gender	Marital status	Relationship to contract holder
☐ Male ☐ Female	☐ Married ☐ Single	

Do you provide over one half of the AID's support? ☐ Yes ☐ No

Does the AID live full-time with the employee/retiree as a member of your household? (If the natural or adoptive parents live apart, living with the other parent will satisfy this requirement.) ☐ Yes ☐ No

If "No" to either question, please explain: _____

Is the AID currently employed? If yes, provide a description of his/her employment; include if part-time, full-time. _____

Section 3: Other insurance policies for this AID

Does the AID have Medicare, Medicaid, Employer Health Plan, other insurance coverage? ☐ Yes ☐ No If "Yes," complete the next two rows.

Insured's Name/Contract Holder	Medicare/Medicaid/Employer Health Plan/Other

Employee Name	Effective date (MM/DD/YYYY)

Will this policy replace other insurance? ☐ Yes ☐ No If "Yes," complete the next two rows.

Insured's Name/Contract Holder	Medicare/Medicaid/Employer Health Plan/Other

Employee Name	Effective date (MM/DD/YYYY)	Cancellation date (MM/DD/YYYY)

Is the dependent currently receiving Social Security benefits? ☐ Yes ☐ No

If "Yes," what was the effective date? _____ If "No," have benefits been denied? ☐ Yes ☐ No

I certify that the above information is correct and authorize the release of medical information requested with respect to this certification.

Signature of contract holder	Date (MM/DD/YYYY)
X	

Section 4: Diagnosis/Prognosis — Must be completed and certified by a physician

Type of disability	Date of disability (MM/DD/YYYY)

Diagnosis	ICD-10 code(s)

What is the Prognosis? If disability isn't lifelong, please describe estimated number of months or years. _____

In your opinion, is the above named dependent currently incapable of self-sustained employment? ☐ Yes ☐ No

In your opinion, will the dependent ever be capable of self-sustained employment? ☐ Yes ☐ No

If "Yes," provide estimated date of return to full functionality: _____ (MM/DD/YYYY)

Physician name	Physician signature	Date (MM/DD/YYYY)
	X	

Physician street address	City	State	ZIP code

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