

Medical Coverage Extension for Eligible Dependent Children



Please be sure ALL information below is complete to avoid delays in processing.
Please print clearly using blue or black ink.

The Patient Protection and Affordable Care Act (PPACA) allows parents to cover dependent children up to the age of 26.

If you have dependent children who are under the age of 26 and wish to add them to your medical coverage, please complete the information below.

Section 1 Employer Information (To be completed by plan administrator.)			
Subscriber name		BCBSRI member ID number	
Social security number		Group name	
Group number		Dept. number	
Section 2 Dependent Information (If necessary, please attach dependent addendum.)			
Dependent #1 First name	Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)		Social Security number (xxx-xx-xxxx)*	
Primary care physician (PCP) name, street, city/town, state, and ZIP code (mandatory for BlueCHiP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider ID		
Dependent #2 First name	Last name	M.I.	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)		Social Security number (xxx-xx-xxxx)*	
Primary care physician (PCP) name, street, city/town, state, and ZIP code (mandatory for BlueCHiP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider ID		
Dependent #3 First name	Last name	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter	
Date of birth (mm/dd/yyyy)		Social Security number (xxx-xx-xxxx)*	
Primary care physician (PCP) name, street, city/town, state, and ZIP code (mandatory for BlueCHiP plans)			
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider ID		

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.hhs.gov/MandatoryInsRep/

Dependent #4 First name	Last name	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter
Date of birth (mm/dd/yyyy)		Social Security number (xxx-xx-xxxx)*
Primary care physician (PCP) name, street, city/town, state, and ZIP code (mandatory for BlueCHiP plans)		
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider ID	

Section 3 Other Insurance Information

Are any of the dependents listed above covered by or eligible for other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of other insurance company and name(s) of covered person(s):
	Covered person 1 _____
	Insurance company _____
	Member ID #1 _____
	Covered person 2 _____
	Insurance company _____
	Member ID #2 _____

To be eligible for coverage, your dependent child must be under 26 years of age.

By signing this form, I certify that the dependent child(ren) listed above meets the definition of dependent as established by PPACA.

SIGN
HERE

Signature of applicant

Date

Application rec'd date _____ ID # _____

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.hhs.gov/MandatoryInsRep/

