Request for Extension of Dependent Child Coverage

I request that _____, whose date of birth is _____, be included on my Blue Cross & Blue Shield of Rhode Island health coverage family membership and/or Blue Cross Dental family membership. He or she:

i) is my natural child, legally adopted child, or stepchild; and
ii) is unmarried; and
iii) is medically certified as disabled; and
iv) is chiefly dependent on me for support and care because of mental impairment or physical disability.

I agree to notify BCBSRI, as appropriate, of any change in the dependent child's status as certified in this Request for Extension of Dependent Child Coverage form.

I have enclosed the requested documentation and answered the following questions truthfully:

1. Parent's Identification Number: _____

2. Has an application for disability coverage under Social Security or any other State or Federal program been submitted? YES ! NO !

3. If yes, what were the results?

_____
_____
_____

4. If approved for benefits, please list SSI or Medicare claim number: _____

5. If no, why has no application for disability been submitted?

_____
_____
_____

6. Please submit at least one item such as an Individual Education Plan, a letter from an employer or state employment department, or other information, which documents how your child's education, employment, and/or other activities may have been affected by his or her condition.

7. Please have your child's physician complete the enclosed Medical Certification form.

Applicant's Signature: _____ Date: _____