HIGHMARK. UNIVERSAL DISABLED DEPENDENT CERTIFICATION

INSTRUCTIONS

1. Parent/Legal Guardian should complete the first page of the form, enter information on the first line on page two and then forward to the doctor who treats your dependent for this disability to complete the second page. Please mail or fax the completed form as instructed on page two.
2. Incomplete applications will be returned.
3. Highmark has final approval on all applications.

SECTION ONE - CUSTOMER INFORMATION

Customer's Last Name (last name of parent/legal guardian)	First Name	Middle Initial	Telephone Number (include area code)

Customer's Address (street, city, state, zip code)

Identification Number	Account Number or Employer Name

SECTION TWO - DEPENDENT INFORMATION

Dependent's Last Name	First Name	Middle Initial	Marital Status ☐ Single ☐ Married

Dependent's Birth Date	Dependent's Relationship To Customer ☐ Son ☐ Daughter ☐ Other *(explain)*:	Dependent's Address (If different than above)

Is dependent employed? ☐ Yes ☐ No	If Yes, Name of Employer

Is this dependent eligible for coverage under another health plan? ☐ Yes ☐ No	If **Yes**, Please explain. If Plan is with Highmark, provide ID Number.

Do you or another parent/legal guardian chiefly support or provide more than 50% support of the dependent? ☐ Yes ☐ No

Has dependent been covered by parent/legal guardian continuously prior to (and after if applicable) reaching the maximum dependent age? ☐ Yes ☐ No
If yes, and carrier was not Highmark, please provide HIPAA certificates of coverage to show dependent was continuously insured.

SECTION THREE - TERMS AND SIGNATURE

I REQUEST COVERAGE FOR THE DEPENDENT NAMED ABOVE WHO IS DISABLED.

I understand and agree that:

1. Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer, association and Highmark.
2. I certify that all representations and information supplied by me are true. My coverage shall be void if any part of this application is false or incomplete.
3. I authorize any hospital, physician, professional review organization and any and all other providers of service to disclose and furnish to Highmark and/or its agents any and all records relating to the disabled dependent named in this application for whom services or benefits have been sought or to whom services or benefits have been provided, including a complete diagnosis and medical information.
4. Attestation/Affidavit:
   I certify that the above information is true and correct to the best of my knowledge, information and belief. I understand that providing false, inaccurate or misleading information could result in recission of coverage, claim denial, and/or legal action against me by Highmark or my employer.

I HAVE READ AND DO AGREE TO THE ABOVE TERMS *By entering your name on the signature line below, you understand that you are creating an electronic signature which has the same effect as a written signature, and you are representing that you have reviewed and submitted this form accordingly. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.*

Signature of Customer (please hand sign if this is a paper request)	Date

Health benefits or health benefit administration may be provided by or through Highmark Blue Cross Blue Shield, Highmark Coverage Advantage or Highmark Health Insurance Company, all of which are independent licensees of the Blue Cross and Blue Shield Association. The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

IMPORTANT!

PLEASE HAVE PHYSICIAN COMPLETE THIS SIDE OF THIS APPLICATION.

DISABLED DEPENDENT APPLICATION

Dependent's Last Name	First Name	Middle Initial	Dependent's Birth Date

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Physician's Name
Physician's Address (street, city, state, zip code)
Physician's Telephone Number (include area code)
Diagnosis of Condition Causing Disability (Indicate degree of severity)

Is this disability permanent? ☐ Yes ☐ No	If No, will the disability last at least twelve months? ☐ Yes ☐ No
Current medications or treatment for this disability	
Treatment or services that may be needed in the near future for this disability	

Date dependent was last treated (month, day, year)	Is dependent incapable of self-support by reason of a mental/physical disability? ☐ Yes ☐ No	If Yes, date dependent became incapable of self-support (month, day, year)
Is dependent confined in an institution? ☐ Yes ☐ No	If **Yes**, Name of Institution	

By entering your name on the signature line below, you understand that you are creating an electronic signature which has the same effect as a written signature, and you are representing that you have reviewed and submitted this form accordingly. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

_____ _____

Signature of Physician (please hand sign if this is a paper request) **Date**

INSTRUCTIONS

1. The form needs to be completed in its entirety (front and back pages).
2. Please see eligibility requirements for a disabled dependent at the top of page 1.
3. Send this form to:

Disabled Dependent Processing
P.O. Box 77
Pittsburgh, PA 15230

Fax: 1-833-732-4026
Email: DEPCERTDEPT@highmark.com

FOR HIGHMARK USE ONLY

HIGHMARK.
An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito.
Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

אכטונג: אויב איר רעדט אידיש, זענען שפראך הילף סערוויסעס, פריי פון אפצאל, אוועילעבל פאר אייך. רופט די נומער וואס איז אויף די פארקערטע זייט פון אייער ID קארטל (TTY:711).

মনোযোগ দিন: আপনি যদি বাংলা ভাষায় কথা বলেন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ রয়েছে। আপনার আইডি কার্ডের পিছনে থাকা নম্বরে ফোন করুন। (TTY:711)

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition.
Appelez le numéro au dos de votre carte d'identité (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711).

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ΠΡΟΣΟΧΗ: Σε περίπτωση που μιλάτε Ελληνικά, οι διαθέσιμες υπηρεσίες γλωσσικής βοήθειας σας παρέχονται δωρεάν. Καλέστε τον αριθμό στο πίσω μέρος της ταυτότητας σας (TTY:711).