Anthem Blue Cross and Blue Shield
Request to Continue Dependent Coverage

Form completion tips

You can use this form if one of your dependents will be too old to stay on your plan, but you want to request to keep them covered. Your dependent may be able to stay on your plan if they are impaired due to a physical or mental illness, injury, or condition. Please refer to your plan documents for complete information about requirements for a dependent to remain covered on your plan.

If you have questions or need help, please call us at the Member Services number on your ID card.

Please fill in all sections on both pages completely. Your request cannot be processed if any information is missing.

If your Anthem Individual health plan was effective on or after January 1, 2014, please mail or fax the completed form to:

CO CT GA IN KY ME MO NH NV OH WI
Anthem Blue Cross and Blue Shield
P.O. Box 659960
San Antonio, TX 78265-9146
Fax: 877-628-4593

If your Anthem Individual health plan was effective before January 1, 2014, please mail or fax the completed form to:

CO CT ME NH NV
Anthem Blue Cross and Blue Shield
P.O. Box 9051
Oxnard, CA 93031
Fax: 877-628-4593

GA IN KY MO OH WI
Anthem Blue Cross and Blue Shield
P.O. Box 659806
San Antonio, TX 78265-9106
Fax: 877-628-4593

If your Anthem plan is through your employer's group plan, please mail the completed form to the address for your state (the state where your employer is headquartered). For complete information about requirements for a dependent to remain covered on your employer-sponsored health plan, please refer to your plan documents, contact your employer, or call us at the Member services number on your ID card.

CO NV (Large Group)
Anthem Blue Cross and Blue Shield
P.O. Box 629
Woodland Hills, CA 91365

CO CT GA IN KY ME MO NH NV OH WI (National Accounts)
Anthem Blue Cross and Blue Shield
6087 Technology Pkwy
Mail Point GA082W-0003
Midland, GA 31820

CT IN KY ME MO NH OH WI (Small Group)
Anthem Blue Cross and Blue Shield
P.O. Box 659960
San Antonio, TX 78265-9146

CT IN KY ME MO NH OH WI (Large Group)
Anthem Blue Cross and Blue Shield
P.O. Box 659210
San Antonio, TX 78265

GA (Small Group and Large Group)
Anthem Blue Cross and Blue Shield
P.O. Box 4445
Atlanta, GA 30302

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Your request cannot be processed if any information is missing.

Section 1: Subscriber information

Last name	First name	M.I.	Member ID no.

Street address	City	State	ZIP code

Phone no.	Employer name	Group no.

Section 2: Dependent information

Last name	First name	M.I.	Date of birth (MMDDYYYY)

Social Security no.	Gender	Marital status	Relationship to subscriber
	☐ Male ☐ Female	☐ Married ☐ Single	

Type of impairment or injury	Date of impairment or injury

Does the subscriber claim the dependent for income tax purposes? ☐ Yes ☐ No
Does the dependent live with the subscriber? ☐ Yes ☐ No
If **no** to either question, please explain: _____

Section 3: Additional insurance policies for this dependent

Does the dependent have another health plan? ☐ Yes ☐ No
Will your Anthem policy replace their other insurance? ☐ Yes ☐ No
If **yes** to either question, complete the following.

Other plan's policyholder name	Date of birth (MMDDYYYY)	Policy no.

Health insurance company name	Other plan phone no.	Other plan group no.

RX Bin	RX PCN	Date coverage started	Date coverage ended

How did they get these benefits? ☐ Through employer ☐ As individual ☐ Another way – describe: _____

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

Medicare – Answer these questions if their other health plan is Medicare.

Name of Medicare cardholder	Medicare claim ID/no.	Effective dates for each part	Medicare entitlement reason
		A: ____ B: ____ C: ____	☐ Age ☐ Disability ☐ ESRD*

*If ESRD (kidney or renal failure) is the primary reason for Medicare, provide the date of first dialysis treatment: ____
and transplant date if applicable: ____

Signature required

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

Signature of subscriber **X**	Date (MMDDYYYY)

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

Diagnosis	ICD-10 code(s)
Describe the dependent's limitations in performing daily activities and ability to manage their affairs	

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: (MMDDYYYY)

Physician name	Physician signature **X**	Date (MMDDYYYY)

Physician street address	City	State	ZIP code

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