

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 you or any of your dependents listed above covered by 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.			
		_____	
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/

