# OVERAGE INCAPACITATED DEPENDENT VERIFICATION FORM

**This section is to be completed by the employee.**

Employee Name: _____ Employee SS#: ☐☐☐-☐☐-☐☐☐☐

Dependent Name: _____ Dependent SS#: ☐☐☐-☐☐-☐☐☐☐

Dependent Sex: Male [ ] Female [ ] Dependent Date of Birth: ____/____/____

Dependents relationship to the policy holder: _____

Does this dependent rely upon you solely for support? Yes [ ] No [ ]

Is the dependent currently employed? Yes [ ] No [ ] If yes:

- Is the employment: Full time [ ] Part time [ ]
- How long has the dependent been employed? _____
- What are the dependents job responsibilities? _____

Employee signature: _____ Date: _____

**This section must be completed and signed by the dependents physician.**

Patients Name: _____ Age: _____

Is the patient presently incapacitated and wholly prevented from engaging in any and every occupation or performing any and all work for compensation or profit to the extent of being incapable of self-support due to:

- A mental condition: Yes [ ] No [ ]
- A physical condition: Yes [ ] No [ ]

What is the patient's functional age level? _____

When was the patient first treated? _____ Last treated? _____

Is the patient ambulatory? Yes [ ] No [ ]

If yes, does the patient require assistance with ambulation? Yes [ ] No [ ]

If assistance is required with ambulation, what type of assistance is needed? _____
_____

Please provide the diagnosis and medical history related to this patient's incapacitation. Attach separate pages if necessary. _____
_____
_____

Name, specialty, address and phone number of physician completing this form: _____
_____
_____

Physician signature: _____ Date: _____

***This form must be completed legibly and in its entirety.

**Return to:**
BlueCross BlueShield
I-20@Alpine Road
Medical Affairs
AX-720
Columbia, SC 29219