Horizon Blue Cross Blue Shield of New Jersey

P.O. BOX 20189
NEWARK, NEW JERSEY 07101-9786

IMPORTANT: READ INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS PRIOR TO COMPLETING ATTACHED FORM

INSTRUCTIONS TO SUBSCRIBER

1. Read the ELIGIBILITY REQUIREMENTS below.
2. Provide the information requested in boxes 1 through 28 of PART I.
3. Read the conditions contained in PART I, sign and date where indicated.
4. Forward the form to the dependent's attending Practitioner TOGETHER with the enclosed return envelope.

INSTRUCTIONS TO THE PRACTITIONER

1. Provided all information requested in PART II. (on reverse side of application)
2. Forward the completed form to:

   HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY, INC.
   PO BOX 20189
   NEWARK, NEW JERSEY 07101-9786

CONDITIONS NECESSARY TO ESTABLISH ELIGIBILITY

1. The dependent is unmarried
2. The incapacitating condition started before the age specified policy age limit.
3. The dependent must have been insured before the age limit of the policy. If insured by another carrier before applying to Horizon BCBSNJ, documentation should be provided.
4. The application for continuation of enrollment must be filed within 31 days from the date the dependent reaches policy age limit.
5. The subscriber must provide proof of the dependent's incapacitation by submitting responses to the following questions at the time of application for continuation of enrollment.
6. Frequency for reassessment of continuation determined by dependent's condition and contract requirements.

Horizon

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NEWARK, NEW JERSEY 07101-9786

REQUEST FOR CONTINUANCE OF ENROLLMENT FOR A DISABLED DEPENDENT (51+ ELIGIBLES)

PART I - TO BE COMPLETED BY SUBSCRIBER

1. SUBSCRIBER'S NAME	2. TELEPHONE # ( ) -	3. SOCIAL SECURITY NO.
4. ADDRESS Street	City	State Zip
5. DEPENDENT'S NAME	6. RELATIONSHIP TO SUBSCRIBER	7. DEPENDENT'S BIRTHDATE / 8. DATE OF ONSET OF DISABILITY / HANDICAP
9. NAME OF PRESENT INSURANCE CARRIER FOR DEPENDENT		10. ID # / POLICY #
11. GROUP #	12. COVERAGE START DATE	13. COVERAGE END DATE
14. Please indicate prior insurance carrier since onset of disability / handicap CARRIER NAME		15. ID # / POLICY #

16. GROUP #	17. COVERAGE START DATE	18. COVERAGE END DATE	*Attach any additional information on separate page*

19. WHY ARE YOU APPLYING FOR CONTINUATION OF BENEFITS FOR THE DEPENDENT AT THIS TIME?

20. CAN THE DEPENDENT PERFORM ACTIVITIES OF DAILY LIVING (ADL - e.g. bathing, dressing, eating)?
YES NO If NO, please explain:

21. IS THE DEPENDENT CAPABLE OF TRAVELING TO AND FROM A DESTINATION UNATTENDED?
YES NO

22. DOES THE DEPENDENT WORK FOR WAGES?
YES If YES, give name of employer:

23. IS DEPENDENT ELIGIBLE FOR HEALTH COVERAGE THROUGH HIS, HER EMPLOYER?
YES NO

NO If NO, give reason(s) why unable to work:

24. IS DEPENDENT IN COLLEGE / SPECIAL SCHOOL OR CONFINED TO AN INSTITUTION?
YES NO If YES, give name/location: Type of program or course of study:

25. DOES THE DEPENDENT RECEIVE OR HAS THE DEPENDENT EVER RECEIVED VOCATIONAL TRAINING DESIGNED TO INCREASE INDIVIDUAL FUNCTIONALITY?
If so name: If not, why not:
dates:

26. WHAT ARE THE SPECIFIC WAYS IN WHICH YOU SUPPORT OR MAINTAIN THE DEPENDENT?

27. HOW / WHAT TYPE OF CARE DO YOU PROVIDE FOR THE DEPENDENT?

28. HAS THE DEPENDENT APPLIED FOR SSI / MEDICARE / MEDICAID? (circle all applicable)
If not, why:

In accordance with amendments to the New Jersey laws governing health service corporations whereby the enrollment of mentally impaired and/or physically disabled children who attained termination age on and after August 10, 1966 may, under certain conditions, be continued under their parent's Horizon Blue Cross Blue Shield of New Jersey, Inc. coverage beyond such termination age, I herewith request such continuation of enrollment on behalf of my child named above.

I UNDERSTAND AND AGREE that continuation of enrollment for the child named above, if approved, may remain in effect only as long as the mental impairment and/or physical disability and dependency exist, and so long as Horizon Blue Cross Blue Shield of New Jersey, Inc. coverage, in my name or in the name of my spouse, if any, remains in force, with no greater than thirty day lapse between any changes in coverage, and provided that coverage is at all times of the type which includes such child. I FURTHER UNDERSTAND AND AGREE that the Plan shall have the right to require periodic recertification as to eligibility for continued extension of dependency coverage.

I represent that to the best of my knowledge and belief the information given above is correct, that the child named above meets the eligibility requirements as to unmarried status and enrollment under my coverage, and is dependent upon me for more than one-half of his(her) support and maintenance.

Subscriber's Name: _____ *Date:* _____

(OVER)

PART II - TO BE COMPLETED BY DEPENDENT'S ATTENDING PHYSICIAN

Questions to be answered by the dependent's Attending Practitioner:
(If disability is due to mental or psychiatric disorder, please have the appropriate behavioral health provider complete form).

1. Specific diagnosis(s) (Use ICD9 or DSMS codes as applicable.) _____

2. If mentally impaired, define mental impairment in terms of mental age _____ IQ _____ or functional capacity in work, educational or social setting.
   Please attach results or summary of most recent testing done to define dependent's functional level.

   _____

   _____

   _____

3. If physically impaired, define physical impairment in terms of capacity to perform activities normally done by individuals of comparable age, intellectual capacity.

   _____

   _____

   _____

4. Is the condition temporary or permanent? _____ Is the condition static or progressive? _____

5. Is the condition currently controlled with medical management? If No, why not _____

   If Yes, specify therapy _____

6. If dependent is attending college, working, or in a training program, what makes this individual more reliant on parent support and maintenance than his/hers non disabled peers and thus make continuation of enrollment under parent's policy necessary.

   _____

7. In your opinion, is the dependent able to work, attend school or a vocational training program? Now: Yes No In the Future: Yes No

   If no, why not? _____

   _____

   _____

   _____

I hereby certify that I am a practicing _____ duly licensed in the State of _____ and certify to the correctness of this information provided above.

Please print the following information	PRACTITIONER'S NAME
	PRACTITIONER'S ADDRESS

SIGNATURE OF PRACTITIONER	PHONE #	DATE SIGNED
	( ) -	

PART III - TO BE COMPLETED BY PLAN

Continuation of enrollment of the dependent named above under his(her) parent's coverage (is) (is not) approved. This certification applies to all coverages.

Authorized Signature: _____ Date: _____