Medical Coverage Extension for Eligible Dependent Children

Blue Cross Blue Shield of Rhode Island

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 ☐ Son ☐ 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? ☐ Yes ☐ No	Provider ID		
Dependent #2 First name	Last name	M.I.	Relationship ☐ Son ☐ 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? ☐ Yes ☐ No	Provider ID		
Dependent #3 First name	Last name		Relationship ☐ Son ☐ 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? ☐ Yes ☐ 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/

continued ➤

Dependent #4 First name	Last name	Relationship ☐ Son ☐ 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? ☐ Yes ☐ No	Provider ID	

Section 3 Other Insurance Information

Are you or any of your dependents listed above covered by other insurance? ☐ Yes ☐ 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.

SIGN HERE ☞

_____

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/

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