DISABLED DEPENDENT APPLICATION FOR C.O.P.S. HEALTH TRUST

C.O.P.S. HEALTH TRUST

Blue Cross Blue Shield Blue Care Network of Michigan

PLEASE COMPLETE THE FORM BELOW. KEEP A COPY OF THE COMPLETED FORM FOR YOUR RECORDS.

SECTION A: SUBSCRIBER INFORMATION

NAME	CONTRACT NUMBER

DATE OF BIRTH (MM/DD/YYYY)	MARITAL STATUS	SEX
	◯ SINGLE ◯ MARRIED	◯ MALE ◯ FEMALE

PRIMARY RESIDENCE: STREET ADDRESS	CITY	COUNTY	STATE	ZIP CODE

OTHER RESIDENCE (IF ANY): STREET ADDRESS	CITY	COUNTY	STATE	ZIP CODE

HOME PHONE NUMBER	DAY TELEPHONE NUMBER

SECTION B: DEPENDENT INFORMATION (PLEASE LIST YOUR INCAPACITATED DEPENDENT.)

FIRST NAME	LAST NAME	SOCIAL SECURITY NUMBER

RELATIONSHIP	SEX	DATE OF BIRTH (MM/DD/YYYY)
	◯ MALE ◯ FEMALE	

DATE CONDITION DEVELOPED (MM/DD/YYYY)	DIAGNOSIS

SECTION C: MEDICARE INFORMATION

IS THE DEPENDENT ENTITLED TO MEDICARE AS A RESULT OF THIS CONDITION? ◯ YES ◯ NO

SECTION D: OTHER INSURANCE

IS THE DEPENDENT CURRENTLY COVERED BY HEALTH INSURANCE OTHER THAN THIS COPS TRUST PLAN OR MEDICARE? ◯ YES ◯ NO
(IF YES, PLEASE COMPLETE BELOW.)

NAME OF INSURED	INSURANCE COMPANY NAME

INSURANCE COMPANY ADDRESS: STREET/P.O. BOX NUMBER	CITY	STATE	ZIP CODE

GROUP OR POLICY NUMBER	CONTRACT TYPE	POLICY EFFECTIVE DATE (MM/DD/YYYY)
	◯ SINGLE ◯ FAMILY	

SECTION E: ADDITIONAL INFORMATION

SECTION F: VERIFICATION

I am requesting that the dependent listed above be included under my coverage through COPS Trust. I understand that this dependent may be covered under my coverage if:

- My dependent is incapable of self-support because of a physical or mental incapacity that existed prior to the end of the month he/she turned age 26.
- My dependent relies on me for support and maintenance.

I certify that I have read the entire application. I also certify that the statements and answers given are complete and correct to the best of my knowledge. I have provided supportive documentation on my dependent's disability as requested above and am aware that without proper documentation coverage may be denied. I am also aware that additional information may be required to make a determination of coverage, and that presenting this documentation does not imply automatic coverage.

SUBSCRIBER'S SIGNATURE (DO NOT PRINT) _____ DATE SIGNED _____

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SECTION G: DEPENDENT'S ATTENDING PHYSICIAN CERTIFICATION (COMPLETED BY PHYSICIAN)

DATE OF FIRST EXAMINATION (MM/DD/YYYY)	DATE OF LAST EXAMINATION (MM/DD/YYYY)	FREQUENCY OF VISITS

DIAGNOSIS/DISABILITY (INCLUDE ICD10 CODE)

CLINICAL INFORMATION: (MEDICAL SUMMARY DOCUMENTING ALL ITEMS LISTED CAN BE ATTACHED TO FORM IN LIEU OF COMPLETING THIS SECTION)

ONSET (SPECIFY DATE)	TEST OR DATA ESTABLISHING DIAGNOSIS

OTHER MEDICAL PROBLEMS

CURRENT MEDICATIONS AND TREATMENT PLAN (INCLUDE EXPECTED DURATION)

IS THIS A PSYCHIATRIC DISABILITY? IF YES, PLEASE COMPLETE THIS SECTION AND ADDRESS THESE ITEMS IN YOUR NARRATIVE REPORT.
COMPLETE DSMTV DIAGNOSIS REQUIRED WITH DESCRIPTORS, CODES AND SEVERITY SPECIFIERS:

◯ AXIS I ◯ AXIS II ◯ AXIS III ◯ AXIS IV ◯ AXIS V GAF, CURRENT: _____ GAF, HIGHEST (PAST YEAR): _____

IS THE DEPENDENT ABLE TO INDEPENDENTLY MANAGE HIS OR HER OWN FINANCES? ◯ YES ◯ NO

IS THE DEPENDENT FULLY COMPLIANT WITH TREATMENT? ◯ YES ◯ NO

IF NO, PLEASE EXPLAIN. _____

WOULD THE PROGNOSIS BE DIFFERENT IF THE DEPENDENT WERE COMPLIANT? ◯ YES ◯ NO

HAS THE DEPENDENT BEEN HOSPITALIZED FOR A PSYCHIATRIC CONDITION? ◯ YES ◯ NO DATES AND FACILITY: _____

WHAT IS THE NATURE AND DEGREE OF THE DEPENDENT'S IMPAIRMENT IN THEIR CAPACITIES FOR:

DAILY ACTIVITIES? _____

TASK PERFORMANCE? _____

SOCIAL INTERACTION? _____

IF DISABILITY INVOLVES DEVELOPMENTAL DELAY OR INTELLECTUAL DETERIORATION, HAS IQ TESTING BEEN PERFORMED? ◯ YES ◯ NO

RESULTS: _____ DATE PERFORMED (MM/DD/YYYY): _____

IF NOT, WHAT INTELLECTUAL FUNCTIONS CAN BE PERFORMED, E.G. MATH, READING, COMPREHENSION, MEMORY SKILLS)

_____

IS THE DEPENDENT: ◯ AMBULATORY ◯ NON-AMBULATORY ◯ BED CONFINED ◯ WHEELCHAIR CONFINED ◯ HOUSE CONFINED
◯ HOSPITAL/INSTITUTION CONFINED FACILITY NAME _____

PROGNOSIS OF TOTALLY DISABLING CONDITION:

◯ PERMANENT AND TOTAL ◯ PERMANENT AND PARTIAL (%) _____

◯ TEMPORARILY DISABLED WITH EXPECTED RETURN TO FULL FUNCTION (%) RETURN DATE _____

◯ TEMPORARILY DISABLED WITH EXPECTED RETURN TO PARTIAL FUNCTION (%) RETURN DATE _____

IS THE DEPENDENT CAPABLE OF SUPPORTING HIMSELF/HERSELF THROUGH GAINFUL EMPLOYMENT? ◯ YES ◯ NO

SECTION H: VERIFICATION

I certify that the above statements are relative to the disabled dependent named on the reverse side are true and complete to the best of my knowledge and belief.

PHYSICIAN'S NAME	PHYSICIAN'S SPECIALTY	LICENSE NUMBER

PHYSICIAN'S ADDRESS	PHYSICIAN'S SIGNATURE	DATE SIGNED