



Horizon Blue Cross Blue Shield of New Jersey

P.O. BOX 607 DEPT. A
NEWARK, NEW JERSEY 07101-0607

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. Provide 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.
P.O. BOX 607 DEPT. A
NEWARK, NEW JERSEY 07101-0607

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.

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

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.

<i>Please print the following information</i>	PRACTITIONER'S NAME
	PRACTITIONER'S ADDRESS

SIGNATURE OF PRACTITIONER	PHONE # () -	DATE SIGNED
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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: _____