



**Arkansas
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

Arkansas Blue Cross Blue Shield
 ATTN: HIPAA Unit
 PO Box 2181
 Little Rock, AR 72203-9974
 Fax 501- 378-2926
 Email: QuoteHIPAA@arkbluecross.com



Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

Health Advantage
 ATTN: HIPAA
 PO Box 2181
 Little Rock, AR 72203-9974
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**PROOF OF INCAPACITY OF A DEPENDENT
SUBSCRIBER'S FORM**

Subscriber Name _____ Subscriber ID# _____

Subscriber SSN# _____ Home Phone _____

Address _____ Work Phone _____

Group Name _____ **Group Number** _____

Dependent Name _____ Dependent SSN _____

Sex: Male Female Date of Birth _____ Relationship to Subscriber _____

Primary Care Physician _____ Date Disability Began _____

Indicate which activities the dependent is able to perform without assistance:

Yes	No	
		Dress Self
		Bathe
		Walk
		Cook Meals
		Housework

Yes	No	
		Manage Finances
		Drive
		Be Employed
		Manage Medications
		Shop for Food/Necessities

Is dependent covered by any other health insurance including Medicare or Medicaid? Yes No

If yes, give policy numbers, effective date, name and address of other insurance company and name in which policy is held: _____

I certify that the above information is true and correct and that the dependent listed above is, by reason or mental retardation or physical incapacity.

Subscriber Signature Date

Group Administrator Signature (if new member) Date