New Mexico Public Schools Insurance Authority

BlueCross BlueShield of New Mexico

Impaired Dependent Certification

Complete this form and return to your employer's benefit office if the following situation applies to you:

Your dependent who is mentally or physically impaired is 25 years old and currently on your health plan. Please submit this form the month before your dependent turns age 26.

Part 1 (To be completed by Employee)

Employee's Last Name, First, Middle Initial	Employee's Social Security Number	
Mailing Address		
Dependent's Last Name, First, Middle Initial	Dependent's Date of Birth:	Dependent's Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced

When did the impaired status occur? ____________________

Provide details: ____

____

____

Is dependent reliant on you for support? ❑ Yes ❑ No

If yes, what percentage of support do you contribute?

Was dependent ever employed? ❑ Yes ❑ No Is dependent employed now? ❑ Yes ❑ No

(If yes, write name and address of current or last employer.)

Summary of any institutional care (names of institutions and dates):

Nature of care:

I hereby declare that all statements and answers to the above questions are complete and true.

Signature of Employee:____ Date:_______________

Part II (To be completed by the attending physician) (List multiple physicians on separate sheet of paper)

Note: The applicant is responsible for the completion of this form without expense to the insurance carrier.

Is this dependent incapable of self-sustaining employment because of mental or physical impairment? ❑ Yes ❑ No	May the dependent be employed in the future? ❑ Yes ❑ No ❑ Questionable
Nature and cause of incapacity:	Date of onset:
Prognosis:	Please indicate results of any intelligence test:

Physician Name: ______________________________
Type or Print

Physician's Signature: ______________________________

Physician's Degree: ______________________________

Telephone Number: ______________________________

Physician's Mailing Address: ______________________________

Part III (To be completed by the School Benefits Administrator)

School Name: ______________________________

School Address: ______________________________

Contact Person (Employee's Benefit Specialist): ______________________________

Phone Number: ______________________________ Date: ______________________________

Part IV (To be completed by NMPSIA Eligibility Administrator)

Effective date of Employee's Insurance: ______________

Effective date of dependent coverage: ______________

Has Employee's dependent coverage been continuously in effect up to the present date? ❑ Yes ❑ No
Please explain:

NMPSIA Eligibility Representative: ______________________________ Phone Number: 1-800-233-3164

Date: ______________________________

Comments:

Eligibility Representative Signature: ______________________________ Date: ______________

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