BlueCross BlueShield BluePlus of Minnesota

APPLICATION FOR DEPENDENT GRANDCHILD

P.O. Box 64560
St. Paul, MN
55164-0560
651.662.8000
1.800.382.2000
www.bluecrossmn.com

TO BE COMPLETED IN FULL BY CONTRACTHOLDER

Any questions unanswered or incomplete may result in a delay of processing or denial of coverage for the requested dependent.

1. Name of Contract holder (Print Last, First, Middle Initial	2. Group No.	3. Contract No.

4. Address (Number, Street, City, State and Zip Code.

5. Name of Dependent Child	6. Dep. Child's Date of Birth	7. Marital Status
		Single Married Widowed Divorced

Child listed under number 5 refers to your, son, daughter, or stepchild who is parent of the grandchild your are requesting coverage for.

8. Name of Grandchild	9. Grandchild's Date of Birth	10. Grandchild's Sex
	/ /	☐ Male ☐ Female

11. Are your child and grandchild residing in your home? ☐ Yes ☐ No
If "no" please explain:

12. Is your child and grandchild depending on you for support? ☐ Yes ☐ No
If "YES" what percent?

_____% Child _____% Grandchild

13. Did you list your child and grandchild as dependents on your last federal income tax? ☐ Yes ☐ No
If "No" please explain:

14. Do you have legal custody of this grandchild? _____ If yes, date _____

15. Do you have physical custody of this grandchild? _____ If yes, date _____

16. Is this grandchild eligible for coverage/health care benefits elsewhere? _____

I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge and belief.

_____ : _____
Signature of Contract Holder Date

_____
Telephone Number

Use this space for additional comments or information:

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