ASURIS NORTHWEST HEALTH

Asuris Northwest Health
528 East Spokane Falls Boulevard
Suite 301
Spokane, WA 99202

Please return the completed form.
By Mail: PO Box 1106 MS:LD2N
Lewiston, ID 83501
By Fax: 1 (877) 369-3407

Affidavit of Qualifying Incapacitated Dependent Eligibility for Individual Coverage

SECTION 1 - STATEMENT OF DEPENDENT'S ELIGIBILITY (to be completed by the Contract Holder)

Contract Holder's Name | ID Number

Contract Holder's Address | City | State | ZIP Code
State xxxxx-xxxx

Dependent's Name | Dependent's Birthdate (mm/dd/yyyy)

Dependent's Relationship to Contract Holder | Marital Status: ☐ Single ☐ Married

Dependent's Address (if not residing with contract holder) | City | State | ZIP Code
State xxxxx-xxxx

Please explain why dependent does not reside with contract holder.

Is dependent currently employed? ☐ Yes ☐ No | Date Employment Began (mm/dd/yyyy)
Position Held | Average Hours Worked Per Week

Dependent's Current Employer's Name

Current Employer's Address | City | State | ZIP Code
State xxxxx-xxxx

Was dependent previously employed? ☐ Yes ☐ No | Dates of Employment (mm/dd/yyyy) to (mm/dd/yyyy)
Position Held | Average Hours Worked Per Week

Does dependent have other health insurance coverage? ☐ Yes ☐ No
If yes, please provide the name of the carrier, contract holder's name, policy number and carrier's phone number:

Is the dependent eligible for or have Medicare coverage? ☐ Yes ☐ No
If yes, please provide the type of coverage, effective date and the Medicare Number (please include the alpha prefix):

Has the dependent been declared disabled by the Social Security Administration? ☐ Yes ☐ No
If yes, what is the date of acceptance? (mm/dd/yyyy) (please attach a copy of the SSI acceptance letter)

I certify that _____, meets the following criteria:
Name of incapacitated dependent (please print)

1) Has been continuously covered by health insurance as my dependent with no break in coverage of more than 63 days **(please submit proof of continuous coverage with this affidavit)**;
2) Is incapable of self-sustaining employment due to incapacitation related to developmental disability, medical disability, and/or mental health and that was present before age 26; and
3) For a child over age 26, is significantly dependent upon contract holder (and/or contract holder's spouse) for support and maintenance.

▶ _____ (mm/dd/yyyy) _____
Signature of Contract Holder **Date**

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