ULTIMATE HEALTH PLANS

Special Supplemental Benefits for the Chronically Ill (SSBCI) Attestation

To be eligible to receive the additional benefits as part of the Special Supplemental Benefits for the Chronically Ill (SSBCI) on your plan, you must have a qualifying chronic condition. Please select at least one diagnosed condition below.

We will verify the presence of the chronic condition with your health care provider. You will not be eligible to receive your SSBCI benefits until we verify your chronic condition. Therefore, please let your doctor know that we will require their verification of the information below. Please provide us with accurate contact information for your doctor or other health care provider on this form.

Once we verify the presence of the chronic condition, your benefits will be available on your Ultimate Benefit Card within seven business days. When this happens, we will backdate your benefits so that you receive all of the benefit dollars you were eligible for starting from your effective date.

Do You Have a Chronic Condition?

I have been diagnosed by my doctor with the following chronic health condition(s). *(Check all that apply)*

- ❒ Chronic alcohol use disorder and other substance use disorders (SUDs)
- ❒ Autoimmune disorders
- ❒ Cancer
- ❒ Cardiovascular disorders
- ❒ Chronic heart failure
- ❒ Dementia
- ❒ Diabetes mellitus
- ❒ Overweight, obesity, and metabolic syndrome
- ❒ Chronic gastrointestinal disease
- ❒ Chronic kidney disease (CKD)
- ❒ Severe hematologic disorders
- ❒ HIV/AIDS
- ❒ Chronic lung disorders
- ❒ Chronic and disabling mental health conditions
- ❒ Neurologic disorders
- ❒ Stroke
- ❒ Post-organ transplantation
- ❒ Immunodeficiency and Immunosuppressive disorders
- ❒ Conditions associated with cognitive impairment
- ❒ Conditions with functional challenges
- ❒ Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell
- ❒ Conditions that require continued therapy services in order for individuals to maintain or retain functioning

Health Care Provider Contact Information

PROVIDER LAST NAME:

PROVIDER FIRST NAME:

PHONE NUMBER: ( ) —

FAX NUMBER: ( ) —

Beneficiary Information

LAST NAME:

FIRST NAME:

MI:

SIGNATURE:

TODAY'S DATE: *(MM/DD/YYYY)* / /