

2026 SSBCI Eligibility Request Form

Member First Name:	Member Last Name:	
Member ID:	Date of Birth:	Plan Name (from your ID card):

I attest to having one of the following conditions: Check box

- **Autoimmune disorders**
 - Polyarteritis nodosa
 - Psoriatic Arthritis
 - Polymyalgia rheumatica
 - Dermatomyositis
 - Scleroderma
 - Polymyositis
 - Rheumatoid arthritis
 - Systemic lupus erythematosus
- **Cancer** (excluding pre-cancer conditions or in-situ status)
- **Cardiovascular disorders**
 - Cardiac arrhythmias
 - Chronic heart failure
 - Coronary artery disease
 - Peripheral vascular disease
 - Chronic venous thromboembolic disorder
- **Chronic alcohol or drug dependency**
- **Chronic and disabling mental health conditions**
 - Bipolar disorders
 - Major depressive disorders
 - Paranoid disorder
 - Schizophrenia
 - Schizoaffective disorder
- **Chronic gastrointestinal disease**
 - Pancreatitis
 - Inflammatory bowel disease
- **Non-alcoholic fatty liver disease**
- **Hepatitis B or C**
- **Chronic kidney disease**
 - Must be on dialysis
- **Chronic lung disorders**
 - Asthma
 - Chronic bronchitis
 - Emphysema
 - Chronic Obstructive Pulmonary Disease (COPD)
- **Conditions associated with cognitive impairment**
 - Dementia
 - Alzheimer's
- **Diabetes**
- **Immunodeficiency and Immunosuppressive disorders**
 - HIV
- **Neurologic disorders**
 - Amyotrophic lateral sclerosis (ALS)
 - Fibromyalgia
 - Chronic Fatigue Syndrome
 - Spinal Cord Injury
 - Epilepsy
 - Cerebral Palsy
 - Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia)
 - Huntington's disease
 - Multiple sclerosis
 - Parkinson's disease
 - Polyneuropathy
 - Spinal stenosis
 - Stroke or related neurologic deficit
- **Post-organ transplantation care**
- **Severe hematologic disorders**
 - Aplastic anemia
 - Hemophilia
 - Immune thrombocytopenic purpura
 - Myelodysplastic syndrome
 - Sickle-cell disease (excluding sickle-cell trait)

Please check this box if you are the beneficiary or authorized representative to confirm the request above.

If authorized representative, please complete the information below:

Name:	Phone Number:
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Address: