Request for Continuation of Medical Coverage for Disabled Student* *or* Handicapped Child

(*applies to eligible dependents of subscribers in MD, ME, MI, NH, NY, VA, VT, and WI)

Employee Instructions:

Handicap Child requests:
Complete Sections 1 through 8 on this form.

Disabled Student requests:
Complete sections 1 through 7 **and** section 9.

Then:

- Please print the information requested, with the exception of the signature section.
- Ask your physician to complete the Attending Physician's Statement and return form to you.
- Send or fax this completed form along with the completed Attending Physician's Statement to: **Aetna**
  P.O. Box 981106
  El Paso, TX 79998-1106
  FAX: 859-455-8650

You and your employer will be notified of the denial or approval of this request.

Note:

Aetna has the right to:

- Require proof of the continuation of the handicap.
- Examine or require examination of your child (at his/her/your own expense) as often as needed while the handicap continues.
- Require an exam no more than each year after 2 years from the date your child reached the maximum age.

Continuation of coverage will cease on the first to occur of:

- Cessation of handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of your dependent child coverage for reason other than reaching the maximum age.

1. Employee Information

Name	Social Security Number

Address (street, city, state, zip code)

2. Employer Information

Name	Policy Number	Effective Date of Coverage

3. Prior Plan Information

Was dependent covered under a prior plan?
☐ No ☐ Yes If Yes, date prior plan started ________ ended ____________

Name and Telephone Number of Prior Carrier

4. Employee Statement

I represent that, to the best of my knowledge and beliefs, the statement and answers made by me on this form are complete and correct. I understand that continuation of coverage for a handicapped dependent is subject to approval by Aetna based on the applicable health benefits plan and on the documentation submitted to Aetna in support of this request for continuation of coverage.

Employee's Signature ____ Date _________________

5. Physician Information

Attending Physician's Name

Attending Physician's Address (street, city, state, zip code)

Attending Physician's Telephone Number

6. Employee Signature and Release

To all providers of health care:
You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claims administrators, consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate a request for coverage. This authorization is valid for the term of the plan under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Employee's Signature ____ Date _________________

7. Dependent Information

Name	Birth Date (MM/DD/YYYY)	Social Security Number

8. Handicap Child Information

When did the incapacity start?
☐ Mental Incapacity Date ____________________
☐ Physical Incapacity Date ____________________

How does the incapacity prevent the dependent from supporting him- or herself?

Schools or Jobs

Has this dependent been attending school or a training facility since reaching the limiting age of the plan?
☐ Yes ☐ No
Education Level Reached ____________

List Schools/Facilities Attended Name of School/Facility	Dates (mm/dd/yyyy) From	To	Custodial Care Facility
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Work History

Has dependent been working?

☐ Yes ☐ No If Yes, provide name of employer and dates of employment:

Name	Dates of Employment	Hours worked weekly	Hourly Wage	Description of duties

If No, what is it about the dependent's incapacity that prevents employment?

Living Arrangements

Does dependent live at home?

☐ Yes ☐ No If No, where does the dependent live? ______________________________

Financial Support

Do you regularly provide more than one-half the financial support for this dependent?

☐ Yes ☐ No If No, please explain:

Do you claim this person as a dependent for Federal Income Tax purposes?

☐ Yes ☐ No

Is this dependent eligible for any other privately or publicly funded health benefits?

☐ Yes ☐ No If Yes, please explain:

9. Disabled Student Information

Complete the following for Disabled Student requests in the states of MD, ME, MI, NH, NY, VA, VT, and WI.

Has the dependent stopped attending school/college due to a disability (illness or injury)? ☐ Yes ☐ No

How does the disability (illness or injury) prevent the dependent from attending school/college?

____

Date the dependent stopped attending school/college due to the disability (illness or injury). _____ /_____ /_______

Does the dependent intend to return to school? ☐ Yes ☐ No

Misrepresentation

Attention California, Ohio, Pennsylvania Residents and Residents of states not specified below: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars ($5,000) and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.