Request for Continuation of Coverage for Handicapped Child

Employee Instructions:

- Complete sections 1 through 8 on this form.
- Please print the information requested, with the exception of the signature section.
- Ask your physician to complete the Attending Physician's Statement and return the form to you.
- Send or fax this completed form along with the completed Attending Physician's Statement to: **Aetna**
  PO 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 a reason other than reaching the maximum age.

1. Employee Information

Name	Aetna ID Number
Address (street, city, state, zip code)	

2. Employer Information

Name	Policy Number	Effective Date of Coverage

3. Prior Plan Information

Was the dependent previously covered under the employee's 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 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 to 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
Relationship to Employee:		

8. Handicap Child Information

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

Schools or Jobs

Has this dependent been attending school or a training facility since reaching the limiting age of the plan?	List Schools/Facilities Attended Name of School/Facility	Dates (mm/dd/yyyy) From	To	Custodial Care Facility
☐ Yes ☐ No	____________	________	________	☐ Yes ☐ No
Education Level Reached ________	____________	________	________	☐ Yes ☐ No
	____________	________	________	☐ Yes ☐ No

Work History

Has dependent been working?

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

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

If No, how does the dependent's incapacity prevent 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. Misrepresentation

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 Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
Attention Arkansas, District of Columbia, Rhode Island 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 California Residents: For your protection California law requires notice of the following to appear on this form:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state 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 and Missouri 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 a 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. **Attention Louisiana 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 is guilty of a crime and may be subject to fines and confinement in prison. **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 Maryland Residents:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **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 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 Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **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 Pennsylvania 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 subjects such person to criminal and civil penalties. **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 Texas 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 intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **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.

This document is available in other languages at no cost to you.

Si necesita asistencia lingüística en español, llámenos al número que figura en su tarjeta de identificación (ID) médica.

如需中文协助，请拨打您医疗 ID 卡上的电话号码与我们联络。

Para sa tulong sa wikang Tagalog, tawagan kami sa numero na nasa iyong Medical na ID card.

Dinék'ehjí t'áá háida shíká adoolwoł nínízingo, azee'ál'į́įjí naaltsoos nitł'izí béésh bee hane'é biká'ígíįjį' béésh bee hodíílnih.

Do you need this letter in another language? Call us.

Handicapped Child Attending Physician's Statement/ Behavioral Health Attending Physician's Statement

Please print the information requested, with the exception of the signature section.

Employee Instructions:
- Complete sections 1-3.

Attending Physician Instructions:
- Complete sections 4-6 and return the completed form to the employee.

1. Employer Information

Name (as shown on ID card)	Policy/Group Number

2. Employee Information

Name	ID Number	Birth Date (MM/DD/YYYY)

3. Dependent Child Information

Name	Birth Date (MM/DD/YYYY)

4. Physician's Statement

For medical conditions, please complete section A below.
For behavioral health conditions, please complete sections A and B below.
For all conditions, you may refer to section C below, *Use of the Social Security Disability Guidelines,* to quantify an individual's disability or handicap.

A. Medical and Behavioral Health conditions:

I. **Diagnosis(es):** ______

II. **Date of onset of the handicap:** ______

III. **Objective findings that substantiate impairment:**

______

IV. **Please provide any additional clinical information that supports how the individual's handicap prevents employment (applicable to individuals over age 18):**

______

B. Behavioral Health conditions , please provide:

I. **The individual's IQ score** ______ **and,**

II. **A functional assessment. Include communication ability, presence of intrusive psychiatric symptoms, stability, response to treatment and prognosis** (continue on a separate page if necessary): ______

C. Use of the Social Security Disability Guidelines:

To quantify an individual's disability or handicap, refer to the Social Security disability guidelines found at: **www.ssa.gov/disability/professionals/bluebook/ChildhoodListings.htm** (for dependents age 18 and younger) **OR** **www.ssa.gov/disability/professionals/bluebook/AdultListings.htm** (for dependents over age 18).

Using the appropriate set of guidelines, select the individual's affected body system(s). If your patient qualifies, please document the corresponding "listing" from the guidelines under which the handicap(s) falls.
Note: Satisfying the Social Security listing level impairment requirements does not ensure a determination of disability or handicap under the individual's Aetna plan. These Guidelines are only offered as a means to solicit submission of appropriate clinical information.

Documentation on this form should include:

I. **Diagnosis(es):** ______

II. **Listing number(s):** ______

Documents and medical records showing how the individual qualifies under a Social Security Disability listing must be submitted with this form.

5. Attending Physician Contact Information (required)

Attending Physician's Name, **Telephone Number** and Address (include street, city, state, zip code)	
Attending Physician's Signature (required)	Date

6. Other Treating Physicians

Please list the name, address and telephone number of other physicians or other health care providers you are aware of who are currently treating this individual for his or her mental or physical incapacity.

7. Misrepresentation

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