



Request For Continuation of Medical Coverage For Handicapped Child

Employee Instructions:

- Complete Sections 1 through 7 on this form.
- Ask your physician to complete the Handicapped Child Attending Physician's Statement and return form to you.
- Send this completed form along with the completed Handicapped Child Attending Physician's Statement to:
 - HMO/QPOS plans:** Employer Services Offices (call Member Services telephone number on your ID card for address)
 - All other plans:** Service Center address shown on your ID card
- 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 your child (at its own expense) as often as needed while the handicap continues.
 - require an exam no more often than once 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 _____
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3. Prior Plan Information	Was dependent covered under a prior plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date prior plan started _____ ended _____	Name and Telephone Number of Prior Carrier _____
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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 _____
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5. Physician Information	Attending Physician's Name _____
	Attending Physician's Address (street, city, state, zip code) _____

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 claim administrators and 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 _____
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7. Dependent Information	Name _____	Birthdate (MM/DD/YYYY) _____	Social Security Number _____
	When did the mental or physical incapacity start? _____	How does the incapacity prevent the dependent from supporting him or herself? _____	

Schools or Jobs

Has this dependent been attending school or training facility since reaching the limiting age of the plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Education Level Reached _____	List Schools/Facilities Attended	Dates (From - To)	Custodial Care Facility
	Name of School/Facility _____	_____ to _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	_____	_____ to _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	_____	_____ to _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Work History

Has dependent been working? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, where does the dependent live? _____
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Financial Support

Do you regularly provide more than one-half the financial support for this dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain: _____	Is this person claimed by you as a dependent for Federal Income Tax purpose? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is this dependent eligible for any other privately or publicly funded health benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____	

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant. California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

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.