Questionnaire for Verification of Student Medical Leave of Absence or Handicapped/Disabled Dependent Eligibility

CIGNA

DATE	SUBSCRIBER'S NAME (EMPLOYEE)	DEPENDENT'S NAME	
SUBSCRIBER'S ADDRESS STREET:	CITY:	STATE:	ZIP CODE:
NAME OF HEALTH PLAN:		HEALTH PLAN CODE:	ID NUMBER
GROUP NAME			GROUP/DIVISION NUMBER

Please complete either section A or B, then sign and date the bottom of the Questionnaire.

Please return the Questionnaire with the appropriate documentation in the enclosed envelope.

A. Student Medical Leave of Absence

_____ Named dependent is eligible for Student Medical Leave of Absence under federal or state law. Please refer to your booklet/certificate or contact your employer's Benefits Administrator for specific federal and/or state requirements. Please note that the dependent must have previously been covered as a student by CIGNA in order to qualify for a Student Medical Leave of Absence.

Please review the requirements for c ertification documentation as indicated below.

_____ Written certification from the treating physician **has not** previously been provided to CIGNA. Please submit written certification from the treating physician, stating that the dependent is suffering from a serious illness or injury and that a student medical leave of absence, or other change in enrollment, is medically necessary.
Note: For convenience, the treating physician may wish to complete the Student Medical Leave of Absence section within the enclosed "Physician Form for Handicapped/Disabled Dependent."

_____ Written certification from the treating physician **has been** previously provided to CIGNA.
Note: It is not necessary for you to re-submit the certification documentation at this time. CIGNA will refer to the documents already received.

B. Handicapped/Disabled Dependent Verification

_____ Named dependent remains legally dependent on the employee/subscriber for support and qualifies for continued coverage under the plan terms because he/she is physically or mentally handicapped/disabled. Please check your booklet/certificate or contact your employer's Benefits Administrator for specific plan terms.

Please answer the following questions and explain your dependent's cognitive and/or physical impairment.

1. Dependent's date of birth_____

2. Is your dependent currently on Social Security Disability? Yes_____ No_____
   If yes, please provide a copy of the letter that supports Social Security Disability determination or awards that support such determination.

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3. Has your dependent been declared by a court to be eligible for a state welfare or assistance program? Yes_____ No_____
   If yes, please provide a copy of the supporting documentation.

4. Has your dependent completed and graduated from high school?
   Yes_____ Date of graduation: _____
   No_____ Last grade attended: _____ Current grade attending: _____
   Never attended high school: _____

5. Is your dependent's condition severe enough to have required placement in a special school or education classes? Yes_____ No_____ Not capable of attending school/classes_____

   If yes, when and for what period of time? _____

6. Does your dependent have the ability to make decisions regarding life skills (e.g., independent financial management, shopping, or living arrangements)? Yes_____ No_____
   If yes, please provide examples below.

7. Does your dependent require constant supervision? Yes_____ No_____
   If yes, please describe supervision examples below.

8. Please describe below any limitations your dependent has in performing daily living activities such as eating, dressing, grooming, toileting, or maintaining personal hygiene.

9. Please describe below any limitations your dependent has in functioning in a social environment (e.g., ability to interact with others outside the immediate family, ability to complete tasks, etc.)

10. Has your dependent been employed since becoming handicapped/disabled? Yes_____ No_____
    If yes, has your dependent experienced an inability to perform or complete tasks in either a work or work-like setting? Yes_____ No_____
    If yes, please provide details below.

Please submit any additional information you would like to be considered in the eligibility review process.

Please Continue on Next Page

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.

I, _____, hereby depose and say, under penalty of perjury, that:

1. I am over eighteen years of age and understand the obligations of an oath.

2. The information provided above is true and complete to the best of my knowledge.

Signature: _____

Printed Name: _____

Date: _____