CIGNA
HealthCare

Questionnaire for Verification of Handicapped Adult Dependent Eligibility

DATE	SUBSCRIBER'S NAME (EMPLOYEE)	DEPENDENT'S NAME	
NAME OF HEALTH PLAN:		HEALTHPLAN CODE:	ID NUMBER
GROUP NAME			GROUP/DIVISION NUMBER

Please complete, sign/date this Questionnaire.
Please return the Questionnaire with the appropriate documentation to the address on the back of your CIGNA ID card.

Handicap/Disabled Dependent Verification

Is this Dependent:
Your natural child, step-child, or adopted child or a child that a court has ordered you to support? Yes No
Your grandchild? Yes No
Married? Yes No
Primarily dependent on you for support or legally dependent on you for support? Yes No
Continuously incapable of self-sustaining employment as a result of a mental or physical handicap? Yes No
Please describe the mental or physical handicap:

When did this handicap become severe enough to prohibit self-sustaining employment:
Before your child reached the limiting age for a dependent under your plan? Yes No
While your child was covered as a full-time student? Yes No

Please return this Questionnaire with the enclosed Physician Form completed by the attending physician. If your child has received an Award of Social Security Disability Benefits, you may submit it with your completed Questionnaire instead of the Physician Form.

_____ Named dependent does not qualify for continued coverage as a handicapped dependent under the plan terms.

Verification of dependent eligibility may be requested periodically.

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: _______________________