



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

(\*applies to MD, ME, NH and NY dependents)

### Employee Instructions:

- Complete Sections 1 through 7 on this form.
- Complete **\*\*Disabled Student** section for Disabled Student requests for MD, ME, NH and NY.
- Please print the information requested, with the exception of the signature section.
- Ask your physician to complete the Handicapped Child/Disabled Student Attending Physician's Statement and return form to you.
- Send this completed form along with the completed Handicapped Child/Disabled Student 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 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?<br><input type="checkbox"/> No <input type="checkbox"/> Yes | Name and Telephone Number of Prior Carrier |
| If yes, date prior plan started _____ ended _____   |  |

### 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 (required) \_\_\_\_\_ Date \_\_\_\_\_

### 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 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 (required) \_\_\_\_\_ Date \_\_\_\_\_

### 7. Dependent Information

|  |                        |  |
|--|------------------------|--|
| Name   | Birthdate (MM/DD/YYYY) | Social Security Number   |
| When did the incapacity start?<br><input type="checkbox"/> Mental Incapacity Date _____<br><input type="checkbox"/> 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?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>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?  
 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?  
 \_\_\_\_\_