Cigna.

Global Health Benefits

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

DATE:	CUSTOMER'S NAME (EMPLOYEE):	DEPENDENT'S NAME:		
CUSTOMER'S ADDRESS	Street:	City:	State / Province:	Postal / ZIP Code:
	District:	Country:		
CUSTOMER ID NUMBER:				
CLIENT (EMPLOYER'S) NAME:		CLIENT ACCOUNT NUMBER:		

Please complete Section A or B, as appropriate, sign, and date the bottom of the Questionnaire.

Please return the Questionnaire with the appropriate documentation.

A. Student Medical Leave of Absence

_____ Named dependent is eligible for Student Medical Leave of Absence under US federal or state law. Please refer to your booklet/certificate or contact your employer's Benefits Administrator for specific US 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 certification 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.

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.

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

Global Health Benefits

Physician Form for Handicapped/ Disabled Dependent Eligibility

DATE:	CUSTOMER'S NAME (EMPLOYEE):		DEPENDENT'S NAME:	
CUSTOMER'S ADDRESS	Street:	City:	State / Province:	Postal / ZIP Code:
	District:	Country:		
CUSTOMER ID NUMBER:				
CLIENT (EMPLOYER'S) NAME:		CLIENT ACCOUNT NUMBER:		

This form should be completed and signed by the primary treating physician for the dependent named above.

Please mail the completed form to:

Cigna Global Health Benefits
Attn: Medical Management
P.O. Box 15050
Wilmington, DE 19850
Facsimile: (302) 797-3482

Treating Physician Information				
Physician Name:				
Specialty:		License Number:		
PHYSICIAN'S ADDRESS	Street:	City:	State / Province:	Postal / ZIP Code:
	District:	Country:		
Telephone Number:		Fax Number:		
Diagnosis(es) (ICD-9) , , ,				
For International Providers – Please provide a description of the diagnosis.				

A. Student Medical Leave of Absence:
Please complete this section of the form if the patient is requesting a Student Medical Leave of Absence.

Does this patient qualify for a medically necessary Student Medical Leave of Absence? Yes_____

No_____ If yes, please provide a short explanation below:

B. Handicapped/Disabled Dependent:
Please complete this section of the form if the patient is requesting certification of handicapped/ disabled status. Please answer the following questions and describe, in as complete a manner as possible, the extent of your patient's behavioral, cognitive and/or physical impairment which prevents gainful employment. This information will assist Cigna in determining this patient's eligibility for continued medical and/or dental coverage as a handicapped/disabled dependent.

1. What is the patient's diagnosis? _____
2. When was the patient's condition _____ initially diagnosed?
3. How long have you treated the patient for the specific conditions which impact his/her ability to be gainfully employed?
   Number of years _____ Frequency of visits_____

Please complete questions 4–11 if your patient is requesting certification of handicapped/ disabled status due to Behavioral Health, Cognitive and/or Neurological Impairment (otherwise, skip to question 12):

4. How many hospital admissions have occurred for this diagnosis/condition in the past 12 months?

5. How many hospital admissions have occurred for this diagnosis/condition **prior to** the past 12 months?

6. Has the patient had an IQ test? Yes_____ No_____
   If yes, what was the result?

7. Describe any cognitive or psychological impairment and the impact created on personal life skills and social interaction:

8. Please provide objective abnormal physical examination findings (e.g., neurological deficit, contractures, loss of joint motion, etc):

9. Please identify any functional limitations that impair self-sustaining employment:

10. Is the condition static/permanent? Yes_____ No_____
    If no, when do you anticipate your patient's condition to improve?
    3 months _____ 6 months _____ 1 year_____ more than 1 year _____

11. Is this patient able to participate in a training or other educational program to achieve the skills necessary to reach self-sustaining employment? Yes_____ No_____

    If yes, when do you anticipate that your patient will be capable of self-sustaining employment?
    3 months _____ 6 months _____ 1 year_____ more than 1 year _____

Please Continue on Next Page

Please complete questions 12-17 if your patient is requesting certification of handicapped/ disabled status due to Other Medical Impairment (e.g., Cardiac, Gastrointestinal, Musculoskeletal, Respiratory, Visual, etc.)

12. How many hospital admissions have occurred for this diagnosis/condition in the past 12 months?

13. How many hospital admissions have occurred for this diagnosis/condition **prior to** the past 12 months?

14. Please provide objective physical examination findings:

15. Please provide any pertinent recent diagnostic test results:

16. Please identify any functional limitations that impair self-sustaining employment:

17. Is the condition static/permanent? Yes_____ No_____

    If no, when do you anticipate that your patient will be capable of self-sustaining employment?

    3 months _____ 6 months _____ 1 year _____ more than 1 year _____

Physician's Signature: _____

Physician's Printed Name:_____

Date: _____

FRAUD NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.