

370 Harvey Road, Suite 4
Manchester, NH 03103
1-800-562-5254

***Questionnaire for Verification of
Handicapped Adult Dependent Eligibility***

DATE:	SUBSCRIBER'S NAME (EMPLOYEE)	DEPENDENT'S NAME
SUBSCRIBER'S ADDRESS: Street: City: State : Zip Code:		
NAME OF HEALTH PLAN: SchoolCare		HEATHPLAN CODE: 3206140
EMPLOYER NAME:		ID NUMBER:

Please complete and sign/date this Questionnaire on the reverse side. Please return the Questionnaire with the appropriate documentation to the SchoolCare address listed above.

Handicap/Disabled Dependent Verification

1. 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

2. Please describe the mental or physical handicap:

3. 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 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.

Verification of dependent eligibility may be requested periodically.

Please complete this form on the reverse side

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, _____, being duly sworn, 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: _____



HEALTH BENEFIT PLANS

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PHYSICIAN FORM FOR HANDICAPPED DEPENDENT

Please respond to the questions below in as complete a manner as possible. This information will assist SchoolCare/CIGNA HealthCare in determining this patient's eligibility for continued health care coverage as a handicapped dependent.

To Identify the Patient:

Name, Address, and CIGNA HealthCare ID# of Primary Covered Member (Parent):

Patient Name and relationship to the primary covered member:

Patient CIGNA HealthCare ID #:

Account Number (from patient's ID Card):

To Identify the Treating Physician:

Physician Name:

Specialty:

License Number:

Address:

Telephone Number:

Fax Number:

Diagnosis(es) (ICD-9) _____, _____, _____, _____

1. How long have you treated this patient and when did you last see him/her?

2. What is the degree of physical/mental impairment?

3. In your professional opinion, is this patient continuously incapable of self-sustaining employment due to a physical or mental handicap?

Yes No

If yes, please explain.

