

Request for Continuation of Coverage for Disabled Child

Applies to:

Aetna plans

All health benefits and health insurance plans offered, underwritten and/or administered by

Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner | Aetna)

Texas Health + Aetna Health Insurance Company and/or Texas Health + Aetna Health Plan Inc. (Texas Health Aetna)

Allina Health and Aetna Health Insurance Company (Allina Health | Aetna)

Sutter Health and Aetna Administrative Services LLC (Sutter Health | Aetna)



Employee instructions:

- Complete sections 1 through 8 on this form.
- Please print the information requested and sign the form.
- Ask your doctor to complete the attending doctor's statement and return the form to you.
- (Misrepresentation): NY residents please sign and date page 3.
- Send or fax this completed form along with the completed attending doctor's statement to:
PO Box 981106
El Paso, TX 79998-1106
FAX: 859-455-8650

We'll notify you and your employer of the denial or approval.

IMPORTANT: Completion of this form does not guarantee coverage. Please review your plan document to ensure coverage for disabled children exists.

NOTE:

The health plan can:

- Require proof that the disability continues.
- Examine or require examination of your child (at his/her/your expense) as often as needed while the disability continues.
- Require an exam each year beginning two years after your child reaches the maximum age.
- Satisfying the Social Security listing level impairment requirements does not ensure a determination of disability under the individual's Aetna plan. These guidelines are only offered as a means to solicit submission of appropriate clinical information. We use the Social Security guidelines listed in the physician section C to quantify an individual's disability.

Coverage will end when:

- The disability ends.
- You or your child cannot prove the disability continues.
- You refuse to have your child undergo any required exam.
- There is a reason to end it other than your dependent child reaching the maximum age.

1. Subscriber information	Name		Subscriber's ID number
	Address (street, city, state, ZIP code)		
2. Employer information	Name	Plan control number	Effective date of coverage
3. Prior plan information	Was the dependent previously covered under the employee's plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date prior plan started _____ ended _____		Name and telephone number of prior carrier
4. Subscriber statement	I represent that, to the best of my knowledge and beliefs, my statement and answers on this form are complete and correct. I understand that continuation of coverage for a disabled dependent is subject to approval by the health plan based on the applicable health benefits plan and the documentation submitted to the health plan in support of this request. Subscriber's signature _____ Date _____		

5. Doctor information	Attending doctor's name
	Attending doctor's address (street, city, state, ZIP code)
	Attending doctor's telephone number

6. Subscriber 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 the health plan has contracted, information concerning health care advice, treatment or supplies provided to the patient (including that relating to mental illness and/or AIDS/ARC/HIV). We'll use this information 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 I agree that a photographic copy of this authorization is as valid as the original.
	Subscriber's signature _____ Date _____

7. Dependent information	Name	Birth date (MM/DD/YYYY)	Subscriber's ID number
	Relationship to subscriber:		

8. Disabled child information	When did the disability start?
	<input type="checkbox"/> Mental disability Date _____ <input type="checkbox"/> Physical disability Date _____

Schools or jobs

Has this dependent been attending school or a training facility since reaching the limiting age of the plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Education level _____	List schools/facilities attended	Dates (mm/dd/yyyy)		Custodial care facility
	Name of school/facility	From	To	
	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Work history

Has dependent been working?				
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the name of the employer and the dates of employment:				
Name	Dates of employment	Hours worked weekly	Hourly wage	Description of duties
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
If no, how does the dependent's disability prevent employment?				

Living arrangements

Does dependent live at home?
<input type="checkbox"/> Yes <input type="checkbox"/> No If No, where does the dependent live? _____

Financial support

Do you regularly provide more than one-half the financial support for this dependent?	Do you claim this person as a dependent for federal income tax purposes?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, please explain:	
Is this dependent eligible for any other privately or publicly funded health benefits?	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:	

9. Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

Attention Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention California Residents:** For your protection California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** 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. **Attention Louisiana Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison. **Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits. **Attention Maryland Residents:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention Missouri Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, denial of insurance and civil damages, as determined by a court of law. Any person who knowingly and with intent to injure, defraud or deceive an insurance company may be guilty of fraud as determined by a court of law. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **Attention North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or 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 may be a crime and subjects such person to criminal and civil penalties. **Attention Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Attention Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Attention Oregon Residents:** Any person who with intent to injure, defraud, or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties. **Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Texas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or 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 may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law. **Attention Washington Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Attention New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Patient/Member Signature:

Date:

Disabled Child Attending Physician's Statement/ Behavioral Health Attending Physician's Statement

Please print the information requested, and sign the form.

1. Doctor's statement

For medical conditions, please complete section A below.

For behavioral health conditions, please complete sections A and B below.

For all conditions, you may refer to section C below, *Use of the Social Security Disability Guidelines*, to quantify an individual's disability. Documents and medical records showing how the individual qualifies under a Social Security disability listing must be submitted with this form.

A. Medical and behavioral health conditions:

I. Diagnosis(es): _____

II. Date of onset of the disability: _____

III. Objective findings that substantiate impairment:

IV. Please provide any additional clinical information that supports how the individual's disability prevents employment (applicable to individuals over age 18):

B. Behavioral health conditions, please provide:

I. The individual's IQ score _____ and,

II. A functional assessment. Include communication ability, presence of intrusive psychiatric symptoms, stability, response to treatment and prognosis (continue on a separate page if necessary): _____

C. Use of the Social Security disability guidelines:

To quantify an individual's disability, refer to the Social Security disability guidelines found at:

www.ssa.gov/disability/professionals/bluebook/ChildhoodListings.htm (for dependents age 18 and younger) **OR**
www.ssa.gov/disability/professionals/bluebook/AdultListings.htm (for dependents over age 18).

Using the appropriate set of guidelines, select the individual's affected body system(s). If your patient qualifies, please document the corresponding "listing" from the guidelines under which the disability(s) falls.

Note: Satisfying the Social Security listing level impairment requirements does not ensure a determination of disability under the individual's Aetna plan. These guidelines are only offered as a means to solicit submission of appropriate clinical information.

Documentation on this form should include:

I. Diagnosis(es): _____

II. Listing number(s): _____

2. Attending doctor contact information (required)

Attending doctor's name, telephone number and address (include street, city, state, ZIP code)

Attending doctor's signature (required)

Date

12. Other treating doctors

Please list the name, address and telephone number of other doctors or other health care providers you are aware of who are currently treating this individual for his or her mental or physical disability.

Aetna and its affiliates comply with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna and its affiliates provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512

(CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, **TTY: 711**,

Fax: **859-425-3379** (CA HMO customers: **860-262-7705**), **CRCordinator@aetna.com**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019, 800-537-7697** (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Igbo	Inweta enyemaka asụsụ na akwughi ugwo obula, kpoo nomba no na kaadi njirimara gi
Ilocano	Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.
Indonesian	Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၢတၢ်ကမၤကျိၣ်တၢ်မၤစၢ်အတၢ်ဖံးတၢ်မၤတဖၣ် လၢတၢ်အိၣ်ဒီးအပူၤလၢတၢ်နကတၢ်ဟ့ၣ်အိၣ်အကိၣ်ကိးဘၣ်လိတဲဖိနီၣ်ကံၤလၢတၢ်အိၣ်လၢတၢ်နနီၣ်ကိၤ ၁ (၅၅) အလံၤတၢ်ကၤၤ
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla
Kurdish	بۆ دەسپێرێتگۆزارێ بە خزمەتگۆزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی سەر ئای دی (ID) کارتێ خۆت.
Lao	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໃບທາງເປີເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Marathi	आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डवरील क्रमांकावर फोन करा.
Marshallese	Nan bōk jipañ kōn kajin ilo an ejjeļok wōñean ñan kwe, kwōn kallok nōm̄ba eo ilo kaat in ID eo am̄.
Micronesian-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលគិតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áa ni nizaad k'ehjí bee níká a'doowoł doo báááh ílínígóó naaltsoos bee atah nílįigo nanitinígíí bee néého'dólzínígíí béésh bee hane'í biká'ígíí áají' hólne'.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Nilotic-Dinka	Të kɔɔr yin ran de wëër de thokic ke cïn wëu kɔr keek tənɔŋ yin. Ke yin cɔl ran ye kɔc kuony në namba de abac tö në ID kard duɔn de tiit de nyin de panakim kōu.
Norwegian	For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫੋਨ ਕਰੋ।

