Questionnaire for Verification of Full-Time Student or Handicapped Adult Dependent Eligibility

CIGNA HealthCare

DATE	SUBSCRIBER'S NAME (EMPLOYEE)		DEPENDENT'S NAME
SUBSCRIBER'S ADDRESS Street:	City:	State:	Zip Code:
NAME OF HEALTH PLAN:		HEALTHPLAN CODE:	ID NUMBER
GROUP NAME			GROUP/DIVISION NUMBER

Please complete Section A or B, and sign/date this Questionnaire on the reverse side.

Please return the Questionnaire with the appropriate documentation in the enclosed envelope.

A. Full-Time Student Verification.

_____ Named dependent qualifies for continued coverage under the plan terms (e.g. unmarried, primarily supported by the employee, and enrolled in a secondary school, college or university as a full-time student); please check your booklet/certificate for the plan terms that apply to you. *Note that not all plans contain provisions for student coverage.* Please return this Questionnaire with one of the following forms of verification:

- A copy of the **current** semester official class schedule clearly indicating **full-time** student status and/or **total credit hours** (12 credit hours required for undergraduate; 9 credit hours required for graduate), as well as **school name**; OR
- A signed statement from the Registrar or Dean of Students verifying **full-time** student status; OR
- A copy of the current semester tuition bill showing **full-time** student status and/or **total credit hours**.

Please note that the above documentation must include the school's name, the student's name and the semester. In addition, when submitting the documents please provide the account number and ID number located on the front of your CIGNA ID Card. If any of this information is missing it could result in termination of coverage until it is received.

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

_____ My plan does not contain a provision for full-time student coverage.

B. 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 entire Questionnaire with the enclosed Physician Form completed by the attending physician.

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

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, ___________________________________, 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: _______________________________