Family Questionnaire to Confirm Status of a Dependent with Mental or Physical Disabilities

DATE	SUBSCRIBER'S NAME (EMPLOYEE)	DEPENDENT'S NAME
SUBSCRIBER'S ADDRESS (Street)	CITY	STATE ZIP CODE
ID NUMBER	GROUP NAME	GROUP/DIVISION NUMBER

INSTRUCTIONS:

1. Answer the questions in this form.
2. Sign and date it at the bottom.
3. Fax or E-mail it to the address at right.

E-mail:
provisionaladulthandicappedreview@cigna.com
Fax: 1-866-945-7220

IMPORTANT: Please make sure to complete all of this form. Otherwise, we won't be able to process your request.

Is the dependent still legally dependent on the subscriber for support? ☐ Yes ☐ No

Does the dependent still qualify for continued coverage under the plan terms because he/she has a mental or physical disability? ☐ Yes ☐ No

Please check your plan documents or contact your employer's benefits administration for the specific details about your plan.

Please answer the following questions about your dependent.

1. Dependent's date of birth: _____
2. Is your dependent currently receiving Social Security Disability (SSD) benefits? ☐ Yes ☐ No
   If Yes, please provide a copy of the letter that confirms your dependent's SSD status.
3. Has a court declared that your dependent is eligible for a state welfare or assistance program? ☐ Yes ☐ No
   If Yes, please provide a copy of the documents that confirm your dependent's eligibility.
4. Has your dependent graduated from high school?
   ☐ Yes Date of Graduation: _____
   ☐ No Last grade attended: _____ Current grade attending: _____
   ☐ Never attended high school
5. Is your dependent's condition severe enough to require placement in a special school or education classes?
   ☐ Yes ☐ No ☐ Not capable if attending school/classes
   If Yes, when and for how long? _____
6. Does your dependent have the life skills to make decisions about matters such as where to live, shopping/care management, and personal finance? ☐ Yes ☐ No
   If Yes, please provide examples of these skills.

   _____
7. Does your dependent require constant supervision? ☐ Yes ☐ No
   If Yes, please provide examples of this supervision.

   _____

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8. Please describe any limits your dependent has with performing daily living activities. (For example, eating, dressing, grooming, toileting, or maintaining personal hygiene.)

9. Please describe any limits your dependent has with functioning in a social environment. (For example, the ability to interact with others outside the immediate family or to complete tasks.)

10. Has your dependent been employed since becoming mentally or physically disabled? ☐ Yes ☐ No

    If Yes, is your dependent unable to perform or complete tasks in either a work or work-life setting? ☐ Yes ☐ No

    If Yes, please provide details:

11. Is your benefit administrator aware you are submitting these forms for review with Cigna? ☐ Yes ☐ No

    Please submit any additional information you would like us to consider in our review.

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 _____, herby depose and say, under penalty of purjury, that:

1. I am over 18 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: _____ Date: _____

Printed Name: _____