PLEASE READ THIS LETTER. IT INCLUDES IMPORTANT INFORMATION.

Dear Customer,

Attached is a required form that needs to be completed for continued eligibility of your overage (or nearing overage) dependent. Please read the following directions and complete the included form.

What is this form?

The form asks several questions about your dependent. The answers will help us determine continued coverage for the dependent. The form includes sections for the parent/guardian and for the health care provider.

How do you define a disability?

A disabled dependent:

- Meets all other plan rules except for the age limit
- Can't maintain self-sustaining employment due to the disabling condition
- Qualifies as a dependent on the parent or guardian's taxes
- Had the disability before aging out of the plan (or has had continuous coverage under the subscriber's coverage if coming from another insurance carrier)
- Not expected to resolve within a year

What do I do next?

1. Fill out the subscriber and dependent section of the included form. Make sure to fill out all required sections [indicated by an asterisk (*)].
2. Bring this form to your dependent's treating provider to fill out and sign thus confirming status.
3. Email the completed form to ddv@cigna.com or fax to 866.945.7220.

When will I get a response?

Cigna Healthcare will use this form to determine continued eligibility. We will notify you via mycigna.com and your employer via email of our decision. Your employer makes the final determination of the dependent's eligibility and will then advise Cigna to update your benefit status. Your benefits administrator can confirm timing of eligibility updates when applicable.

Sincerely,

Cigna Healthcare

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Handicapped/Disabled Dependent Verification

Please answer the following questions. We require answers to the questions with an asterisk (*) to process.

Subscriber section:

1. Subscriber name: *_____
2. Subscriber Date of birth (MM/DD/YYYY): * _____
3. Subscriber ID: *_____
4. Subscriber Mycigna.com user ID: * _____
5. Subscriber Complete Mailing Address: * _____

Dependent section:

1. Dependent name: * _____
2. Dependent date of birth (MM/DD/YYYY): *_____
3. Is the dependent still legally dependent on the subscriber for support? *

Yes_____ No_____

4. Is the dependent currently receiving Social Security Disability (SSD) benefits? *

Yes_____ No_____

5. Can the dependent make decisions about matters such as where to live, shopping/care management, and personal finance? *

Yes_____ No_____ If yes, please briefly describe *:

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Please describe any limitations the dependent has to performing daily living activities. *

I confirm that the information I have provided above is accurate and true to the best of my knowledge.

Signature/date*: _____

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.

Please have your Treating Provider complete the following section of the form before emailing or faxing.

Treating Provider section:

The following questions must be completed by the dependent's treating provider. We require answers to the questions with an asterisk (*) to process.

1. Provider name (print): * _____
2. License number: * _____
3. Phone: * _____
4. Address: * _____
5. Provider Contact (if other than Treating Provider): _____
6. Patient name: * _____
7. Patient date of birth (MM/DD/YYYY): * _____
8. What is the patient's diagnosis? *

   _____

   _____
9. To your knowledge, when was the patient's condition first diagnosed? (MM/YYYY)*

   _____

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10. Describe any cognitive or psychological impairment along with the impact on personal life skills and social interaction. *

11. Please identify any limitations that prevents self-sustaining employment.*

Is the condition permanent? * Yes_____ No_____

I confirm that the information I have provided above is accurate and true to the best of my knowledge.

Provider signature/date*: _____

Provider Name (Print): _____

Provider Telephone Number: _____

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