

Request for Continuation of Coverage for Disabled Child

Applies to:

All Aetna plans, except Traditional Choice[®] plans

All Innovation Health[®] plans, except indemnity plans

All Health benefits and health insurance plans offered and/or underwritten by Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner|Aetna)

All Health benefits and health insurance plans offered and/or underwritten by Texas Health + Aetna Health Plan Inc. and Texas Health + Aetna Health Insurance Company (Texas 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.
- 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

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.

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.

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

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?
 Mental disability Date _____ 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 Name of school/facility	Dates (mm/dd/yyyy) From To	Custodial care facility
	_____	_____	<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?
 Yes 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?
 Yes No If No, where does the dependent live? _____

Financial support

Do you regularly provide more than one-half the financial support for this dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:	Do you claim this person as a dependent for federal income tax purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No
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 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. **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 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 act, which is a crime and subjects such person to criminal and civil penalties. **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.

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, contact:

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), CRCoordinator@aetna.com.

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 Civil Rights Coordinator.

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	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau tus xov tooj ntawm koj daim npav.
Igbo	Maka enyemaka asụsụ n' ịgbò kpọọ nọmba edèputàrà na kaadi njirimara gi na agwughị ụgwọ o bụla.
Ilocano	Para iti language assistance para iti Ilocano awagan ti numero a nakalista ayan iti ID kard yo nga awanan ti bayadna.
Italian	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa.
Japanese	日本語でのアシストは、IDカードに記載の番号に無料でお電話ください。
Karen	လၢကၠိၣ်တၢ်မၤစၢၤ လၢကၠိၣ်တၢ်အိၣ်ကိၣ် ကိးလိတံၢ်စိနီၣ်ဂံၢ်တၢ်ကွဲးလိယုၣ်လၢနတၢ်မၤနီၣ်မၤယၢဝဲးအလိၤ လၢတအိၣ်ဒီးတၢ်လၢတၢ်ဘျီတၢ်စၢၤတၢ်န့ၣ်တက့ၢ်.
Korean	한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화 번호로 전화해 주십시오.
Kru-Bassa	ʼBé m̄ ké gbo-kpá-kpá dyé dé ʼBásóò wùdùùn w̄ɛɛ, d̄á nòbà b̄é ɔ cééà b̄ó nì dyí-dyoìn-b̄éè̄ k̄ɛ b̄ó pídyi.
Kurdish	بو هاریکاری زمان تاییهت به زمانی خۆت پهیوهندی بکهن به ژماره‌ی بی بهرامبیری نووسراو له کارتێ پیناسی خۆتاندا.
Laotian	ສຳລັບການຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ, ໃຫ້ໂທຫາເບີຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານໄດ້ໂດຍບໍ່ເສຍຄ່າ.
Marathi	मराठीतील भाषा साहाय्यासाठी तुमच्या आयडी कार्डवर सूचीबद्ध करण्यात आलेल्या क्रमांकावर मोफत कॉल करा.
Marshallese	Ñan bōk jipañ ilo Kajin Majeļ kwōn kallok nōm̄ba eo me ej waļok ilo kaat in ID eo aṃ ilo ejjeļok wōṇean.
Mon-Khmer, Cambodian	សម្រាប់ជំនួយជាភាសាខ្មែរ សូមទូរស័ព្ទតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នកដោយឥតគិតថ្លៃ។
Navajo	<i>Naaltsoos bee néhózinigo nanitinígíí béésh bee hane'é numbo bikáá'ígíí áají' hoodítne' díí saad bee yá'át'igo bee nika' adoolwołígíí éí t'áá ník'e Diné bizaadjí níł ádoolníł.</i>
Nepali	नेपालीमा भाषासम्बन्धी सहायता पाउनका लागि तपाईंको परिचय-पत्रमा उल्लेख गरिएको नम्बरमा निःशुल्क कल गर्नुहोस्।
Nilotic-Dinka	Tën ë kuɔony ë thok ë Thuonjāj, ɔl akuën cī reec ë kaad du kōu kec'in ayōc.
Norwegian	For språkassistanse på norsk, ring nummeret på ID-kortet ditt kostnadsfritt.
Pennsylvania Dutch	Fer Hilfe in Deutsch, ruf die Fonnummer aa die uff dei ID Kaarde iss. Es Aaruf koschtet nix.
Persian	برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی
Pohnpeian.	Ohng palien sawas en soun kawewe ni lokaian Pohnpei, koahl nempe me sansal pohn noumw ID koard ni sohte isais.
Polish	Aby uzyskać pomoc językową w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie identyfikacyjnej.
Portuguese	Para obter assistência linguística em português ligue para o número grátis indicado no seu cartão de identificação.
Punjabi	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।
Romanian	Pentru asistență lingvistică în românește, telefonați la numărul gratuit indicat pe cardul de membru.
Russian	Чтобы получить языковую поддержку на русском языке, бесплатно позвоните по номеру, указанному на вашей идентификационной карте.
Samoan	Mō fesoasoani tau gagana i le Gagana Sāmoa vala'au le numera o lo'o lisiina i luga o lau pepa ID e aunoa ma se totogi.
Serbo-Croatian	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj naveden na poledini Vaše identifikacijske kartice.

Spanish	Para obtener asistencia lingüística en español, llame sin costo alguno al número que figura en su tarjeta de identificación.
Sudanic-Fulfude	Heɓa wallende be wolde Fulfulde ewne lamba je dɓon windi ha do dɛrewol modɓon, meere.
Swahili	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa nambari iliyoorodheshwa kwenye Kitambulisho chako bila malipo.
Tagalog	Para sa language assistance na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad.
Telugu	తెలుగులో భాషలో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా మీ ఐడి కార్డు మీద ఉన్న నెంబరుకు కాల్ చేయండి.
Thai	สำหรับความช่วยเหลือทางด้านภาษาเป็น (ภาษาไทย) โทรหมายเลขที่แสดงไว้บนบัตรประจำตัวของท่าน ฟรีไม่มีค่าใช้จ่าย
Tongan	Kapau 'oku fiema'u hā tōkoni 'i he lea faka-Tonga telefoni ki he fika 'oku lisi 'i ho'o kaati ID 'o 'ikai hā tōtōngi
Turkish	Türkçe dil yardımı için kimlik kartınızdaki numarayı ücretsiz olarak arayabilirsiniz.
Ukrainian	Щоб отримати мовну підтримку українською мовою, безкоштовним зателефонуйте за номером, зазначеним на вашій ідентифікаційній картці.
Urdu	لسانی خدمات تک مُفت رسائی کے لیے، اپنے بیمہ کے ID کارڈ پر درج نمبر پر کال کریں۔
Vietnamese	Để được hỗ trợ ngôn ngữ bằng tiếng Việt, hãy gọi đến số được ghi trên thẻ ID của quý vị, miễn phí cước gọi.
Yiddish	פאר שפראך הילף אין אידיש רופט דעם נומער וואס שטייט אין אײער אידענטיפיקאציע קארטל פון אפצאל.
Yoruba	Fún ìrànlowọ nípa èdè Yorùbá pe nọmbà tí a kọ sórí káàdì ìdánimò rẹ lófẹ̀ẹ́.