

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



DATE:	SUBSCRIBER'S NAME (EMPLOYEE)	DEPENDENT'S NAME	
SUBSCRIBER'S ADDRESS:			
Street:	City:	State :	Zip Code:
NAME OF HEALTH PLAN:		HEATHPLAN 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. Forward all materials to:

**CIGNA HealthCare**  
**PO BOX 5750**  
**Scranton, PA 18505**

**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 reflecting full-time student status and/or total credit hours; 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 as a full-time student 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. If your child has received an Award of Social Security Disability Benefits, you may submit it with your completed Questionnaire instead of the Physician Form.

\_\_\_\_\_ 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: \_\_\_\_\_