Request for Extension of Benefits due to Total Disability

Employee Instructions:

- Complete sections 1 through 8 on this form.
- Ask your doctor to complete the Attending Physician's Statement and return the form to you.
- Send this completed form along with the completed Attending Physician's Statement to:

Aetna
PO Box 981106
El Paso, TX 79998-1106
FAX: 859-455-8650

Aetna has the right to:

1. Require proof of the total disability.
2. Examine the individual (at Aetna's expense) as often as needed while the total disability continues.

Extension of benefits will end on the first to occur:

1. The total disability ends.
2. The individual does not prove the total disability exists.
3. The individual does not have any required exam.
4. The individual becomes eligible for coverage under another health benefits plan that includes coverage for the disabling condition.
5. The approval time frame expires.
6. The plan benefits available for the disabling condition run out.

1. Employee Information

Name	Aetna ID Number
Address (street, city, state, ZIP Code)	
Contact Phone Number (day)	Phone Number (evenings)

2. Employer Information

Name	Policy Number	Effective Date of Coverage

3. Disability Information

Name of individual requesting extension of benefits	Birthdate (MM/DD/YYYY)	Aetna ID Number

Relationship to Employee	Name of Primary Disabling Condition	Secondary Conditions
☐ Self ☐ Dependent		

When did the disability start?

☐ Mental disability Date _____

☐ Physical disability Date _____

Is the disabled individual currently receiving Social Security Disability?

☐ Yes ☐ No

If yes, what date did the disability begin, according to the Social Security Administration _____.

On what date will Social Security disability run out? _____

Please attach proof of the Social Security Administration's determination.

4. Employee or Employed Dependent – Complete this section if the request is for the employee or a dependent who is employed.

Job Title when disability began	Description of duties	Does the disability impact you/the dependent's job performance ☐ Yes ☐ No If yes, how?

Work History (Provide the name, dates of employment and a description of duties for the two employers prior to the current position)

1.
2.

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5. Dependent – Complete this section if the request is for a dependent who is not employed

Current level of activity	Is dependent a full-time student? ☐ Yes ☐ No If yes, does the disabling condition prevent the dependent from attending school/college? ☐ Yes ☐ No	Does the dependent require school accommodations? ☐ Yes ☐ No If yes, how?
If the dependent is not a full-time student, does the disabling condition prevent the dependent from being employed or engaging in most of the normal activities of a person who is the same age and sex in good health? ☐ Yes ☐ No If yes, how?		

6. Physician Information – Please list all treating or consulting physicians providing services for the primary disabling condition. Include dates of treatment as indicated.

Physician Name	Physician Telephone Number
Physician Address	Treatment Dates From: ___/___/___ To: ___/___/___

Physician Name	Physician Telephone Number
Physician Address	Treatment Dates From: ___/___/___ To: ___/___/___

Physician Name	Physician Telephone Number
Physician Address	Treatment Dates From: ___/___/___ To: ___/___/___

7. Employee or Dependent (as applicable) 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 claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided to the individual identified above in section #3 (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate a request for extension of benefits. 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 agree that a photographic copy of this authorization is as valid as the original.

_____ _____
Employee or Dependent Signature (Parent/Guardian required for dependents under the age of 17) Date

8. Employee or Dependent (as applicable) Attestation[1]

I represent that to the best of my knowledge and beliefs, the statement and answers made by me on this form are complete and correct. I understand that extension of benefits for total disability is subject to approval by Aetna based upon the applicable health benefits plan and the documentation submitted to Aetna in support of this request for extension of benefits. I attest that I am not employed in any capacity for pay or profit or in the case of a request for one of my dependents, that the dependent is totally disabled. If this request is approved; I will notify Aetna should the disabling condition resolve prior to the end of the coverage period.

_____ _____
Employee or Dependent Signature (Parent/Guardian required for dependents under the age of 17) Date

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[1] 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 and Missouri 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 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.