cigna healthcare + oscar

Disabled Adult Dependent Request Form

PO Box 52146 | Phoenix, AZ 85072

Instructions

Please complete this form to request continued coverage for a disabled adult dependent age 26 or above.

1. Fill out the fields below, sign and date the form
2. Attach the physician's summary. If this is a new enrollment, please also include evidence of continuous coverage for your dependent. (See back of form for details)
3. Return the form and documentation to the following address:

Cigna + Oscar c/o Oscar Management Company
P.O. Box 52146
Phoenix, AZ 85072-2146
OR
email business@hioscar.com ATTN: Eligibility

SUBSCRIBER INFORMATION				
ID Number (if already enrolled)	Name (First, Middle initial, Last)			Social Security Number ______ - ______ - ______
Street Address	Apt/Floor	City	State	Zip Code
Phone Number ( ) -	Email Address			

DEPENDENT INFORMATION			
Name (First, Middle initial, Last)	Date of Birth	Gender M F	Social Security Number ______ - ______ - ______
Dependent Relationship to Subscriber Child Other______________________			

Question	Answer
The dependent listed above is the unmarried child, stepchild or adoptive child of the subscriber and is age 26 or older.	Yes No
The dependent listed above resides with me or my spouse.	Yes No
Has the dependent ever been employed for wages? Currently working at /Worked in the past at ______________________ Hours per week ______________________ Wages per week __________	Yes No
Is the dependent eligible for care under Medicare?	Yes No
Has the dependent been found eligible as disabled by Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)? If yes, documentation is required to evaluate disabled dependent coverage. Example: Notice of award letter.	Yes No

Please read the following carefully.

I certify that I have carefully and fully read the information on the next page of this form. I also certify that the statements and answers given are complete and correct to the best of my knowledge. No information required to be given, either expressly or by implication, has been knowingly withheld. I have provided supportive documentation on my dependent's disability as requested above and I am aware that without proper documentation coverage may be denied. I am also aware that additional information may be required to make a determination of coverage and that presenting this documentation does not imply automatic coverage.

I agree to promptly advise Oscar of any change that affects the adult dependent's eligibility in accordance with the terms of my Oscar policy. I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information, or who conceals, for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act. This may be a crime and I may be subject to a civil penalty.

Subscriber Signature ______________________________ **Date** ______________

Small Group

- **CA members:** We will send a notice prior to your dependent reaching the age of 26. Completed paperwork is required within 60 days of receiving such notice from us. Additionally, a recertification of disability may be required annually to ensure ongoing coverage.
- **GA, TN, and AZ members:** Please be aware that completed paperwork is required within 31 days of your dependent reaching the age of 26. Additionally, a recertification of disability may be required annually to ensure ongoing coverage.

Physician's Summary

The physician's summary must include the following information:

- Description of the disabling condition, including symptoms associated with the disability;
- The extent to which the disability prevents self-sustaining employment and whether accommodation is possible;
- Date at which the disability began; and
- Current prognosis, including an estimate of when self-sustaining employment may be possible.

Please note that the physician's summary must be written on the physician's office stationery and be signed by the dependent's physician. It should include the physician's contact information (phone number, address, and email).

Eligibility Requirements

Eligibility requirements vary by state. Please see your Evidence of Coverage or your policy for more information.