A fully completed form facilitates its processing

Please return this form to:

PRIVATE AND CONFIDENTIAL
Cigna
P.O. Box 69
2140 Antwerpen
Belgium

Request for continuation of coverage for handicapped children

Plan member

Personal reference n° /

Family name and first name

Date of birth (d-m-y) Gender ☐ M ☐ F

Address

Telephone Email

Child

Family name and first name

Date of birth (d-m-y) Age when handicap occured Gender ☐ M ☐ F

Address

Marital status Social security n° (if applicable)

Is your child dependent upon you for support? ☐ No ☐ Yes, please describe support:

Describe your child's handicap

Additional information

Is your child a full-time student? ☐ No ☐ Yes, please provide the name and address of the school:

Has your child ever been employed? ☐ No ☐ Yes, please provide the name, address and dates:

Is your child covered under another group insurance of government plan which will also cover any medical expenses or disability losses? ☐ No ☐ Yes, give name of insurance company or organisation providing benefits:

Name

Address

Policy number

Signature plan member

In view of a smooth administration of the contract and/or settlement of the insurance claim, and only for that purpose, I hereby give my specific and informed consent regarding the processing of the medical data concerning myself and/or the members of my family (article 7 of the Belgian law of December 8, 1992 concerning the private life).

I certify that the above information is to the best of my knowledge and belief correct and true. The issuance of false claims, the provisions of misleading information or the withholding of information related thereto is an offence punishable by Law.

The information provided on or attached to this form may be disclosed to other persons or entities for the purpose of processing this claim and performing medical insurance plan administration.

Date (d-m-y) Signature of the plan member

Attending physician statement

Patient's family name and first name

Patient's date of birth (d-m-y) | Patient's gender ☐ M ☐ F

Patient's address

When did the symptoms first appear?

IQ Tests name | IQ Tests results

Subjective symptoms

Objective symptoms

Date first consulted for this condition | Date last visit | Frequency of visits

Hospital confinement dates

Diagnosis or ICD 9 code

Other physical defects, if any

Medications - type and dose

First date of disability

Was disability continuous for this date to present? ☐ Yes ☐ No, when did disability end?

Degree of Physical impairment? ☐ None ☐ Mild ☐ Severe ☐ Profound

Psychiatric impairment? ☐ None ☐ Mild ☐ Severe ☐ Profound

Is the patient ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

Is the patient capable of holding any type of employment at this time? ☐ No ☐ Yes, comment

Prognosis

Physician's last name and first name

Date of birth (d-m-y)

Address

Telephone | Email

Tax ID n°, Social security n° or practice license number

Signature physician

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Date (d-m-y) | Signature of the physician

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