Application Submission Instructions

Please complete the attached application and send to Health Plan One either via fax or mail:
(must submit by mail if enclosing a check or money order)

Health Plan One
1000 Bridgeport Ave. 4th FL
Shelton, CT 06484

Fax (Toll Free): 888.812.6887

Please make check payable to the carrier to which you are applying.

Any questions? Please call Health Plan One at 1-877.567.5267. Thank you!

Aetna Advantage Plans for Individuals, Families and the Self-Employed* – MO

Applicant's Social Security Number

Enrollment Form ID Number

Instructions and Important Information:

- **Please PRINT clearly**. Enrollment form must be completed by the Applicant in blue or black ink. **No pencil or correction fluid. (A photocopy of this enrollment form will not be accepted.)**
- The Applicant must complete the enrollment form. You are responsible to ensure that the information on the enrollment form is correct, complete, and truthful.
- Any misrepresentation of information on the enrollment form may result in cancellation of coverage.
- The enrollment form must be received by Aetna's underwriting department within 30 days from the signature date.
- You are ineligible for coverage, if as a non-citizen of the United States, you have not resided in the U.S. for six (6) consecutive months.
- **This enrollment form must be completed in its entirety and one (1) form of payment selected or processing time will be delayed.**
- Your insurance will become effective only if this enrollment form is approved as applied for, and the appropriate premium is enclosed.
- Coverage is not guaranteed until approved in writing by Aetna. DO NOT cancel your current insurance coverage until you have been notified of your approval by Aetna and your Aetna coverage is in effect.
- **Signature and date is required on Page 10, Section R for all applicants including spouse/domestic partner/domestic partner and children age 18 and over.**
- PPO products are underwritten by Aetna Life Insurance Company through a blanket trust arrangement in Delaware.
- Once you submit this enrollment form, you may be contacted at any time via telephone by an Aetna representative to complete your enrollment form and the underwriting process. Please do not answer any questions if you are not satisfied with the identity of the caller. Please call **1-866-898-3267** if you have any questions or concerns.

Send completed enrollment form to:

Aetna Advantage Plans
PO Box 14381
Lexington, KY 40512-4381

Aetna Use Only

Prior Coverage: ☐ **Y** ☐ **N** ☐ **U**
Effective Date:

A. Applicant Information

Name			
Mailing Address (All Aetna correspondence will be sent to this address) - Include Apartment Number, if applicable. Number, Street _____ County _____ City, State, ZIP Code _____		Billing Address (If you prefer your bill to be mailed to a different address than listed above) - Include Apartment Number, if applicable. Number, Street _____ City, State, ZIP Code _____	
Telephone Numbers Home ( ) Work ( ) Cell ( )			
Marital Status ☐ Single ☐ Married ☐ Domestic Partner	Occupation	E-mail Address	Do you read and write English? ☐ Yes ☐ No

Choose desired benefit plan type:	**Reason for enrollment form:**
☐ MO MCOA 2500 ☐ MO MCOA 5000 ☐ MO MCOA Value 5000 ☐ MO MCOA High Deductible 3500 (HSA Compatible) ☐ MO MCOA High Deductible 5500 (HSA Compatible) ☐ Preventive and Hospital Care 2750 (HSA Compatible) ☐ Dental (Dental option only available with choice of Medical)	☐ New Enrollment for Aetna Advantage Plans ☐ Add Spouse/Domestic Partner/Dependent Child to an Existing Plan ☐ Add Dependent Child Only to an Existing Plan ☐ Change Existing Benefit Plan (Existing Aetna Advantage Plan Member Only) ☐ Request for Rate Review

Please check if applicable:
☐ I am eligible for health benefits offered by my employer ☐ I am a sole proprietor or I am self-employed

Is any person listed on this enrollment form a "non-citizen resident" of the United States? ☐ Yes ☐ No

If "Yes," has that person(s) resided within the United States for the past six (6) consecutive months? ☐ Yes ☐ No

If "No," provide the name(s) and explanation.

***In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans.**

Applicant's Social Security Number

Enrollment Form ID Number

B. Individuals to be Covered ***(Dependent children are covered up to age 26.)***

☐ ***Check here if more space is needed to provide information for additional dependents. Use a separate sheet of paper and staple to the back of this enrollment form.***

Family Code	Name Last First M.I.	Social Security Number	Date of Birth (MM / DD / YYYY)	Age	Sex (M/F)	Height (ft / in)	Weight (lbs)
APP	Applicant						
SP/DP	Spouse/Domestic Partner						
01	Dependent						
02	Dependent						
03	Dependent						

C. Other Insurance - Please attach copy of Continuation of Coverage Certificate letter for each person, if applicable.

Do you currently have any health care coverage? ☐ Yes ☐ No | Are your spouse/domestic partner/children also covered? ☐ Yes ☐ No

Provide name of current (or most recent) health care carrier and coverage termination date (if applicable).

Name: _____ Term Date: _____

Are any family members listed above currently enrolled in any Aetna Advantage Plan? ☐ Yes ☐ No

If "Yes," provide names and relationship: _____ ID No.: _____

Has any person listed on this enrollment form ever been postponed, had a waiver applied or charged an additional premium for life, disability or health insurance? ☐ Yes ☐ No If "Yes," provide the following information.

Name: _____ Explanation: _____

Has any person ever filed a claim and/or received benefits from disability insurance or Workers' Compensation? ☐ Yes ☐ No

If "Yes," provide the following information.

Name: _____ Date: _____ Explanation: _____

If you are currently covered by another carrier do you agree to discontinue the similar coverage prior to or on the effective date of the Aetna Advantage Plan.

☐ Yes ☐ No If "No," explain: _____

Are any persons listed above eligible for Medicare? ☐ Yes ☐ No Note: If you are currently on Medicare, you are ineligible for an Aetna Advantage Plan.

Name: _____ Name: _____

D. Health History for Applicant and ALL Spouse/Domestic Partner/Dependents (*Include information for all persons applying for coverage.)*

Answer all questions and provide complete details to all "Yes" answers on Page 5, Section F.	**Missing information may delay processing this enrollment form.**

In the past ten (10) years, has any person listed on this enrollment form consulted a health care provider, received treatment (including prescription medications) or been hospitalized for any of the following conditions or diseases?

D1.	**Eyes, Ears, Nose and Throat Conditions/Disorders:** *Eyes/sight:* • Glaucoma, cataracts, crossed eyes, detached retina, corneal transplant, infections *Ears/Hearing:* • Loss of hearing, deafness, infections, eustachian tube dysfunction *Nose/breathing:* • Deviated septum, polyps, adenoiditis, sinusitis *Throat/Swallowing:* • Tonsillitis, strep throat, excessive snoring or sleep apnea	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D2.	**Skin Conditions/Disorders:** Acne, psoriasis, keratosis Birthmarks, dermatitis, eczema, fungal infections, warts, herpes, excessive sweating Moles/pre-cancerous lesions, skin cancer, or melanoma 2nd or 3rd degree burns, scars/keloid, or revisions of cosmetic or reconstructive surgery	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D3.	**Musculoskeletal Conditions/Disorders:** Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as: Strain/sprain, fibromyalgia, gout Fracture, internal/external fixations, permanent hardware, amputation/prosthesis Arthritis, joint replacement, herniated disc	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

continued

Applicant's Social Security Number

Enrollment Form ID Number

D. Health History for Applicant and ALL Spouse/Domestic Partner/Dependents (*Continued*)

D4.	**Respiratory Conditions/Disorders:** Allergies, sinusitis, bronchitis, asthma, pneumonia, collapsed lung, spitting/coughing up blood Shortness of breath, chronic cough, emphysema, COPD, difficulty breathing Tuberculosis, fungal infections	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D5.	**Digestive Conditions/Disorders:** Infections of mouth/throat/tonsils Problems with jaw or chewing, ulcers, hernia, gastric reflux, unexplained weight loss or gain, eating disorder, Gastric Bypass/Banding Colitis, Crohn's Disease, Irritable Bowel Syndrome (IBS), chronic diarrhea, intestinal problems, colon polyps, rectal bleeding or hemorrhoids Diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, jaundice, Cirrhosis	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D6.	**Urinary Conditions/Disorders:** Bladder infections, kidney infections, stones, blood in urine Stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D7.	**Heart and Circulatory Conditions/Disorders:** Anemia, bleeding/clotting disorders, Hemophilia, thrombocytopenia, Varicose/spider veins, Raynauds, phlebitis, thrombosis, enlarged lymph nodes or lymphadenitis High blood pressure (hypertension), low blood pressure, high cholesterol/lipids Chest pain, angina, heart murmur, palpitations, congestive heart failure, coronary artery disease, rheumatic fever Heart attack, bypass surgery/angioplasty, valve replacement, pacemaker or defibrillator, aneurysm	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D8.	**Metabolic and Endocrine Conditions/Disorders:** Diabetes, Insulin Resistance, Metabolic Syndrome, Thyroid disorders Adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis Or other immune disorder (not including the result for the HIV test)	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D9.	**Brain/Nervous System Conditions/Disorders:** Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, narcolepsy, sleep apnea Confusion, memory loss, Alzheimer's, dementia, head injury, seizures/epilepsy Stroke, paralysis, migraine headaches or chronic severe headaches Tremors, Multiple Sclerosis, Muscular Dystrophy, Reflex Sympathetic Dystrophy (RSD)	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D10.	**Male Reproductive Conditions/Disorders:** Fertility/infertility treatment, low sperm count, sexual dysfunction Erectile dysfunction, enlarged prostate, prostatitis, undescended testes Genital or anal herpes/warts, sexually transmitted diseases	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D11.	**Female Reproductive Conditions/Disorders:** a) Pelvic pain, abnormal menstrual bleeding, endometriosis, ovarian cysts, absence of menstruation Abnormal PAP smear, uterine fibroids, fertility/infertility treatment, miscarriage, genital warts/herpes or sexually transmitted diseases Breast cysts/lumps/fibroids, breast implants	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
	b) Has it been more than 40 days since any female listed above had her last menstrual period? If "Yes," provide name(s) and reason: Name(s): _____ Reason(s): _____ _____ _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
	c) **Has any female had an abnormal PAP smear? If "Yes," provide details in F1**. Date of last normal PAP smear. Name: _____ Date: _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
	d) Is any female applying for coverage pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate? If "Yes," provide name: Name: _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D12.	**Nervous, Mental and Behavioral:** Depression, anxiety, obsessive-compulsive or panic disorders, eating disorders, anorexia/bulimia Attention deficit, chemical imbalance, bi-polar, schizophrenia Substance abuse, counseling or support group, alcohol or chemical dependence	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

continued

Applicant's Social Security Number

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D. Health History for Applicant and ALL Spouse/Domestic Partner/Dependents (*Continued*)

D13.	**Cancer/Tumors:** Cysts, tumors or abnormal growths Hodgkin's disease, leukemia or any other cancer or malignancy	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D14.	**Birth Defects/Congenital Abnormalities:** Cerebral Palsy, Birthmarks, developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation Cleft palate/lip, club foot, webbed fingers/toes, skull/facial or other physical deformities	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D15.	**Other Conditions:** Has any person applying for coverage consulted with or received treatment from any doctor or other health care provider for any other known condition or symptom(s) not listed on this enrollment form?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

E. Health Related Questions *(Include information for all persons applying for coverage.)*

Answer all questions and provide complete details to all "Yes" answers on Page 5, Section F.	**Missing information may delay processing this enrollment form.**	
E1.	Is any ***male*** expecting a child or in the process of adoption or surrogacy with anyone whether or not that person is applying for coverage on this enrollment form? If "Yes," provide name below. Name: _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E2.	Has any person applying been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? If "Yes," provide name(s) and date below. Name: _____ Date Discontinued: _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E3.	Has any person applying ever used illegal or controlled drugs, or substances such as marijuana, cocaine, methamphetamines, illegal, or controlled IV drugs? If "Yes," provide name(s)/details below. Name: Type of Drug/Substance: Date Discontinued: _____ _____ _____ _____ _____ _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E4.	Has any person applying consumed any alcoholic beverage in the last 6 months? (Amount: A drink is 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor.) If "Yes," provide name(s)/details below. Name: Type: Amount: _____ _____ _____ per ☐ Day ☐ Week ☐ Month _____ _____ _____ per ☐ Day ☐ Week ☐ Month	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E5.	Has any person applying been convicted of a DUI (drunk driving violation)? If "Yes," provide name(s), state(s) and date(s). Name: State: Date: _____ _____ _____ _____ _____ _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E6.	Has any person applying been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), or ARC (Aids Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E7.	Has any person applying received any lab results, X-rays, MRI or other diagnostic test results or physical exam results from a physician or medical practitioner that were considered **abnormal**?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E8.	Has any person applying been advised to undergo further medical testing, treatment or surgery which has not yet been completed?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E9.	Has any person applying been a patient in an outpatient clinic, hospital, surgical center, treatment center or other medical facility?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E10.	Has any person applying seen any health care provider for any condition, signs, or symptoms which have not yet been diagnosed?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

continued

Applicant's Social Security Number

Enrollment Form ID Number

E. Health Related Questions (*Continued*)

E11.	Has any person applying smoked or used tobacco products, such as snuff and/or chewing tobacco, in the last 2 years? If "Yes," provide name(s) below. Name: Date Stopped:	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E12.	Has any person applying taken prescription medications or been advised to take prescription medications in the last 2 years?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E13.	Has any person applying ever seen, received treatment from, or consulted any health care provider for any other condition or symptom(s) not listed on this enrollment form?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E14.	Is any person applying a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E15.	Is any person applying currently on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

F. Detailed Health Information

☐ ***Check here if more space is needed. Use a separate sheet of paper and staple to the back of this enrollment form.***

1. Provide COMPLETE DETAILS to ALL questions answered "Yes" in Sections D and E.

Family Code*	Ques. No.	Dates From	Dates To	Explain Nature of Illness/Condition	Describe Treatment Recommended and/or Received	Do you consider yourself "Fully Recovered"
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

2. List all prescription medications and/or doctor's samples taken by you and/or your named spouse/domestic partner/dependents within the last 2 years.

Family Code*	Ques. No.	Date Prescribed (Mo./Day/Yr.)	Date Discontinue (Mo./Day/Yr.)	Name of Medication	Dosage and Frequency	Reason/Condition

***See Family Code explanation on Page 2, Section B.**

continued

Applicant's Social Security Number

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F. Detailed Health Information (*Continued)*

3. For details and medications indicated above, please list ALL doctors, medical attendants, or practitioners you and/or any named spouse/domestic partner/dependents consulted. If none, please state "None."

Family Code*	Question Number and/or Reason	Name, Address, and Phone Number of Attending Physician

4. List the last doctor visit for all family members, including routine check-ups.

Family Code*	No Visit	Purpose of Visit	Date of Visit	Results of Visit	Name, Address, and Phone Number of Physician
APP					
SP/DP					
01					
02					
03					

***See Family Code explanation on Page 2, Section B.**

G. Race/Ethnicity – Optional

Family Code*	(This information is designed for the purpose of data collection and will not be used for determining eligibility, rating, or claim payment.)		01	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____
APP	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____		02	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____
SP/DP	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____		03	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____

H. Effective Date (Requesting an effective date DOES NOT GUARANTEE underwriting to be completed before the date requested.)

If Aetna approves my enrollment form, I am requesting an effective date of the ☐ 1st ☐ 15th _____ (month).
This date will be honored provided that Aetna's approval is within 30 days of the requested effective date. This date must be no later than 90 days after the signature date (**Page 10, Section R**) of this enrollment form. **No requested effective date will be honored prior to or on the signature date.**

I. Statement of Enrollment Conditions

Each member of the family will be medically underwritten separately and assigned a separate medical coverage based on his or her own health risk. If one or more family members are not approved, Aetna will cover the approved family members unless otherwise indicated below.

☐ I, the applicant, instruct Aetna not to cover any eligible family members unless all family members are approved for coverage.

☐ I prefer to receive written communication regarding my enrollment form via email.

Applicant's Social Security Number

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J. PAYMENT OPTIONS - Please select the method of payment for your initial enrollment form and subsequent premium payments.

Initial Payment

☐ Easy Pay (complete the EFT information below)
☐ Credit Card (complete the credit card information below)

Recurring or Subsequent Payment

☐ Easy Pay (complete the EFT information below)
☐ Bill me monthly

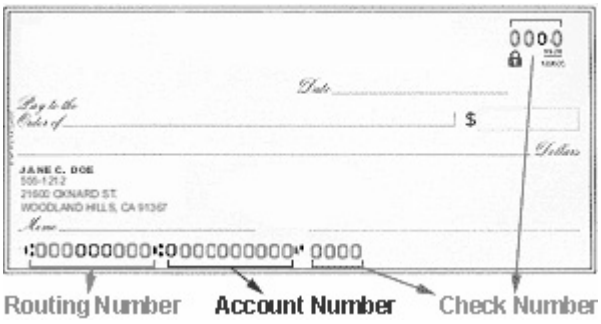
Easy Pay (Electronic Fund Transfer – EFT)

Checking Account Number: _____

Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Bank: _____

Name(s) on Checking Account: _____



Terms of Agreement: My account(s) at the institution named has sufficient funds to pay all debits and charge credits. Aetna shall initiate electronic debit, charge, or credit entries to pay premiums/charges for authorized policies, and the entries are my transaction receipt. There is no payment to Aetna until Aetna receives full and final credit for the payment. I understand that corrections to the entries may involve an account adjustment, and that **my direct electronic payment of Aetna's premium will be debited/charged on or after the premium due date.** I understand that by electing the Easy Pay box above and with my enrollment form signature on **Page 10, Section R**, I am accepting the terms of the Easy Pay Agreement.

Any rate adjustment made in accordance with the underwriting process will be automatically charged to your account upon approval of your enrollment form. Please be advised that such rate adjustment may result in an increase of 0% to 100% of the standard premium.

NOTE: Aetna reserves the right to refuse/terminate electronic payment services at any time. This agreement remains in effect until Aetna/member terminates it. Joint accounts require the signature of ALL account authorized persons (**Page 10, Section R**) even if not applying.

Credit Card Payment Option

Credit Card Type ☐ Visa ☐ MasterCard	Cardholder's Name (exactly as it appears on the card)
Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	Card Expiration Date

Credit card payment is for your initial premium payment only and will be charged upon approval of your enrollment form. You must elect EFT or monthly billing for your next premium payment.

Any rate adjustment made in accordance with the underwriting process will be automatically charged to your account. Please be advised that such rate adjustment may result in an increase of **0% to 100% of the standard premium**.

K. Statement of Accountability - To be completed if the applicant cannot complete the enrollment form.

I _____ in representation of the applicant, acting as _____
(describe your relationship) have personally read this form to the applicant and completed the enrollment form because:

☐ Applicant does not have sufficient command of the English language to complete this enrollment form
☐ Applicant is legally incapacitated and unable to complete this enrollment form

I have read and explained in detail the contents of this enrollment form.

_____

If translated, I also fully explained the "Conditions and Agreement" under **Section Q** to the applicant.

Signature of Representative ***(Required):*** _____ Today's Date ***(Required)***: _____

Print Name: _____

Street Address: _____

City, Zip Code, State: _____ Phone Number: _____

Applicant's Social Security Number

Enrollment Form ID Number

L. Insurance Producer Attestation – To be completed by Insurance Producer/General Agent.

	General Agent	Insurance Broker
1. Did you see the proposed applicant (and spouse/domestic partner, if applying) at the time this enrollment form was executed? If "No," please explain.	☐ Yes ☐ No	☐ Yes ☐ No
2. To the best of your knowledge, is the information on this enrollment form complete and accurate? If "No," please explain.	☐ Yes ☐ No	☐ Yes ☐ No
3. You have explained in easy to understand English (or via translation where applicable) the risk to the applicant of providing inaccurate information on this enrollment form, and that the applicant fully understands your explanation.	☐ Yes ☐ No	☐ Yes ☐ No

Signature of Insurance Producer (Required if applicable)		**Signature of General Agent** (Required if applicable)	
Date	E-mail Address sales@healthplanone.com	Date	E-mail Address sales@healthplanone.com
Name of Insurance Producer or Agency to be assigned as Broker of Record (print name) William C. Stapleton		Name of General Agent (print name) HEALTH PLAN ONE	
TIN of Producer or Agency to be assigned as Broker of Record XXX-XX-9982		Agent TIN Number 20-4098658	
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code) 1000 Bridgeport Ave., 4th Floor, Shelton CT 06484		Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code) 1000 Bridgeport Ave., 4th Floor, Shelton CT 06484	
Telephone Number (877) 567-5267	Fax Number (888) 812-6887	Telephone Number (877) 567-5267	Fax Number (888) 812-6887

M. Aetna Sales Representative

Last Name of Sales Representative (print name)	First Name of Sales Representative (print name)

N. Contact Information

Please return this enrollment form to the agent or submit to the address listed below.

Aetna Advantage Plans
PO Box 14381
Lexington, KY 40512-4381

Fax #: 866-892-8396

Website for information: www.aetna.com/members/individual

O. Important Reminders – Please Review Prior To Signing

To avoid delays in underwriting, please review this enrollment form for missing or incomplete information such as:

- Height and Weight
- Date of Birth
- Physician's address and phone number
- Complete mailing address information, including: city, state and ZIP code
- Complete answers to all Health History questions
- First and Recurring payment options
- **Social Security Number for the primary applicant at the top of each page**
- Social Security Number for each applicant on **Page 2, Section B**
- If additional information or explanation is necessary, attach extra sheets to the back of this enrollment form. **All attachments must include primary Applicants Last Name, First Name and be signed and dated.**

Applicant's Social Security Number

Enrollment Form ID Number

P. PPO Blanket Trust Joinder Agreement

I, _____, have chosen one of the PPO benefit plans. I understand that such PPO plans are underwritten by Aetna Life Insurance Company through a blanket trust and that to be able to join such trust I will have to sign and agree to the terms of this Joinder Agreement. I also fully understand and agree that no coverage shall become or remain effective as to myself or any of my dependents if myself or any of my dependents fail to meet minimum underwriting or eligibility requirements of Aetna. I agree to the enrollment criteria as I myself indicated in the Statement of Enrollment Conditions section of this form.

I agree to the establishment of an insurance trust fund ("Insurance Fund") for the purpose of implementing a Trust Agreement ("Trust Agreement"), and to the designation of The Bank of New York, (Delaware) as "Trustee" for said Insurance Fund and Trust Agreement.

I, the undersigned, as an Applicant under the above Trust Agreement: 1) agree to be bound by the terms of the Trust Agreement and the policy (including all of its attached documentation) issued to the Trustee (including any amendments); 2) request coverage for me and/or my dependents under the policy or policies issued to the Trustee (subject to the applicable underwriting requirements of Aetna) and that such coverage become effective as of the date of my or my dependents approval for participation under the Trust Agreement; 3) agree that the covered benefits provided shall be in accordance and shall be subject to the terms of the policy or policies issued to the Trustee of the Insurance Fund; 4) agree to make the required contributions (e.g., premium payments) to the Insurance Fund; and 5) also agree that in the case of default, fraud or no payment I will be liable to Aetna for such fraud, or unpaid contributions for the coverage period, and Aetna may terminate coverage for me and /or for my dependents.

Applicant's Signature	Today's Date
Applicant's Spouse/Domestic Partner (If applying for coverage)	Today's Date
Applicant's Dependent (Not a minor)	Today's Date

Q. Conditions and Agreement - Please Read Before Signing Below

IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN. By filing this enrollment form and applying for this coverage, I on behalf of myself and the spouse/domestic partner and/or dependents listed on this enrollment form ("Applicant(s)"), agree to or with the following:

1. Aetna may decline this enrollment form. No coverage comes into effect until Aetna approves this enrollment form.
2. Coverage and benefits, once they come into effect, are contingent on timely and accurate payment of premiums and any other contribution provided in the plan documents. If payment of premiums or any other contribution is not paid in time and accurately, your coverage will be terminated immediately. If you are terminated for nonpayment of premium, you may no longer be eligible to enroll in any of Aetna's Plans.
3. I authorize Aetna to request Applicant(s) medical records, any prescribed medication history and any other medical or pharmaceutical information to process this enrollment form and to make a decision on the approval or disapproval of this enrollment form. I authorize any physician, other healthcare professionals, hospitals, clinics, labs, pharmacies, pharmacy benefit managers or any other healthcare organization ("Providers") that provided treatment or any other service to Applicant(s) that are applying for coverage under this enrollment form to disclose the information required by Aetna and described above to Aetna and/or its designated agents. I understand that I may revoke this authorization at any time while Aetna is determining eligibility for the coverage requested. To do so, I must notify Aetna in writing prior to the issuance of the policy. Revocation of this authorization will result in closure of this enrollment form.
4. I understand that Aetna will rely on such information to: 1) underwrite this enrollment form for coverage, make eligibility, risk rating, policy issuance and enrollment determinations for all of the persons applying for coverage; 2) administer claims and determine or fulfill responsibility for coverage and provisions of benefits; 3) administer coverage; and 4) conduct other insurance operations according to federal and state laws and regulations.

   I authorize Aetna to use such information and to disclose such information to affiliates, Providers, payers, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that Aetna will comply with the HIPAA Privacy Rules and that disclosure of such information will be done in accordance with applicable law.
5. I understand that I am entitled, as is any authorized representative that I may designate, to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
6. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice.
7. Agents may be compensated based on an individual's enrollment in this plan. Information on insurance agent/broker compensation is available from your agent or at Aetna.com.

Applicant's Social Security Number

Enrollment Form ID Number

R. Signature(s) Required - All persons applying for coverage age 18 and over must sign and date below.

I understand that if my signature/date do not appear and/or are not current and/or my answers are incomplete this enrollment form will be declined.

I have an obligation of communicating to Aetna in writing any medical conditions which occur to Applicant(s) listed in this enrollment form after the signature date on this enrollment form and before the effective date of the coverage, if approved.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form for insurance or statement of claim containing any material 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.

By signing below, Applicant(s) agree to the statements listed above on this enrollment form and represent that all information supplied on this form is true and complete to the best of their knowledge. Applicant(s) have read, understand, and agree to the conditions of enrollment on this enrollment form. Applicant(s) understand that the information supplied in this form will be decisive for the approval of this enrollment form and that any misrepresentation and/or mistake in such information will be reason for cancellation/termination of the coverage for which Applicant(s) are applying.

If adding dependents: I represent that the child/children listed on this form are my legal dependents.

I understand that Aetna requires a copy of my child's birth certificate, adoption decree or legal documentation of responsibility for purposes of dependent verification.

NOTE: Failure to provide such documentation within 60 days of the date of birth or adoption (unless otherwise required by the state) will be grounds for termination/cancellation of the coverage for the newborn or adopted child/children listed above and all claims incurred will become the financial responsibility of the undersigned member.

Applicant's Signature	Today's Date
Applicant's Spouse/Domestic Partner (If applying for coverage)	Today's Date
Applicant's Dependent (Not a minor)	Today's Date
Applicant's Dependent (Not a minor)	Today's Date

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HIPAA Update

To the Applicant/Spouse/Domestic Partner and Dependent age 18 and older

Please be advised that Aetna may request Applicant(s) medical records, any prescribed medication history and any other medical or pharmaceutical information to process this enrollment form and to make a decision on the approval or disapproval of this enrollment form. Your application authorizes any physician, other healthcare professionals, hospitals, clinics, labs, pharmacies, pharmacy benefit managers or any other healthcare organization ("Providers") that provided treatment or any other service to Applicant(s) that are applying for coverage under this enrollment form to disclose the information required by Aetna and described above to Aetna and/or its designated agents.

Aetna may condition eligibility for enrollment in an Aetna health plan; if you are enrolled, Aetna may not condition eligibility for treatment, payment or benefits, on whether or not you sign this authorization. You understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

You may revoke this authorization at any time while Aetna is determining eligibility for the coverage requested. To do so, you must notify Aetna in writing prior to the issuance of the policy. Revocation of this authorization will result in closure of this application.