Application Submission Instructions

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

HealthPlanOne
35 Nutmeg Drive, Suite 220
Trumbull, CT 06611

Fax (Toll Free): 888.812.6887

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

Any questions? Please call HealthPlanOne at 1-877.567.5267. Thank you!

aetna®

Kentucky 2016
Application for Aetna Individual Health Insurance

Aetna Health Inc.

Primary Applicant's Name

Applicant's Social Security Number

INSTRUCTIONS:

- **Complete in blue or black ink only.**
- **PRINT clearly.**
- **All answers must be complete and truthful.**

IMPORTANT NOTES:

- **The information you provide is confidential.**
- **Intentional misrepresentation may result in the policy being modified or terminated.**
- **Proof of state residency may be required.**

Section A – Primary Applicant Information (for parent/guardian for Child-Only application)

Primary Applicant Last Name	First Name	Middle Initial
Home Address (No PO Boxes)		Apt. Number

City	State	ZIP Code	County

Relationship (If Child-Only Application)

Mailing Address (If different from your Home address)

City	State	ZIP Code

E-mail Address

Telephone Number	If we need to call you with questions about your application, when is the best time to reach you?
Primary (_____) _____ **Secondary** (_____) _____	☐ Morning ☐ Afternoon ☐ Evening

Section B – Application Type

Application Type (Select one):	
☐ New medical coverage	☐ Child-Only Application (Children up to age 21)
☐ Change current coverage	☐ Add dependent(s) to current coverage

Your Effective Date will be assigned by Aetna, based on the receipt date of your application.

Primary Applicant's Name

Section C – Enrollment Period

☐ **Annual Open Enrollment Period** (Annual period to enroll in medical coverage if no Special Enrollment Period applies. If you qualify for a Special Enrollment Period during the Annual Open Enrollment Period, coverage may start sooner.)

☐ **Special Enrollment Period** (If you qualify for a Special Enrollment Period, you can enroll in medical coverage outside the Annual Open Enrollment Period. If you qualify for a Special Enrollment Period during the Annual Open Enrollment Period, coverage may start sooner.)

If one of the events listed below applies to you, check the appropriate box.

The Special Open Enrollment Period for the following events begins 60 days prior to the date of the event checked and continues for 60 days after.

Date of Event	Event
_____	☐ Loss of employer coverage due to termination of employment, reduction in hours, coverage no longer offered to my employment class, or expiration of COBRA coverage.
_____	☐ Loss of employer or individual coverage because no longer eligible as a dependent.
_____	☐ Loss of employer or individual coverage because of divorce from policyholder, death of policyholder, or policyholder enrolled in Medicare.
_____	☐ Loss of Medicaid or CHIP coverage.
_____	☐ Coverage needed following loss of eligibility for Exchange subsidies.
_____	☐ A permanent move.

The Special Open Enrollment Period for the following events begins on the date of the event checked and continues for 60 days.

_____	☐ Coverage needed for new dependent through marriage.
_____	☐ Coverage needed for new dependent through birth, adoption or placement for adoption.
_____	☐ Other, please explain. _____

Section D – Coverage Selection

Choose the plan that best meets your needs.

*** Catastrophic:	Bronze:	Silver:	Gold:
Health Network Only Open Access (HMO)			
☐ Aetna Catastrophic HNOnly PD	☐ Aetna Bronze $40 Copay HNOnly PD	☐ Aetna Silver $10 Copay HNOnly PD	☐ Aetna Gold $10 Copay HNOnly PD
	☐ Aetna Bronze Deductible Only HSA Eligible HNOnly PD		

*** **Must be under age 30 or qualify for an exemption. Proof of exemption will be required for each individual applying.**

Primary Applicant's Name

Section E – Persons Requesting Coverage

List all family members you wish to be covered under this policy.

Dependent children are eligible up to age 26.

For a Child-Only application, start listing children at Child 1, with the youngest child listed first.

☐ Check here if you need more space to provide information for additional dependents. Use a separate sheet of paper and staple to the back of this application.

If any person has regularly used tobacco products (cigarettes, pipe, cigars, snuff, or chewing tobacco) within the last six (6) months, check "Yes" as Tobacco User below (This does not apply to applicants under the age of 18). Regular use means an average of four or more times per week.

If any person uses tobacco for religious or ceremonial purposes only, check "No" for Tobacco User below.

Primary Applicant Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Spouse/Domestic Partner Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 1 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 2 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 3 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No

continued

Primary Applicant's Name

Section E – Persons Requesting Coverage (Continued)

To be completed by the Primary Applicant

Marital Status ☐ Married ☐ Domestic Partner ☐ Single	Are you a resident of the state in which you are applying? ☐ Yes ☐ No
If you are currently covered by accident and sickness insurance, is this plan intended to replace your current coverage? ☐ Yes ☐ No (If "Yes", you must complete the Notice to Applicant Regarding Replacement of Health Insurance in Section K.)	
How would you like Aetna to communicate with you regarding your application and coverage? ☐ E-mail ☐ Mail	Would you like to receive e-mails from us regarding your benefits, programs and general health information? ☐ Yes ☐ No
Would you like to turn off paper? ☐ Yes ☐ No If you turn off paper, we will send you e-mails about your claims and other activity on your account. You can also view your statements and communications online. Please note that there may be state or federal regulations that prohibit us from communicating with you in your preferred method.	
Are any applicants enrolled in or entitled to Medicare benefits? ☐ Yes ☐ No If Yes, provide name(s) of these applicants: _____	
Are all applicants listed on this application Citizens of the United States? ☐ Yes ☐ No If "No," provide Name and most recent date of arrival in the U.S. **Proof of state residency will be required.** Name _____ Most recent arrival date _____ _____ _____ _____ _____	
Do you read and write English? ☐ Yes ☐ No (If "No", you must complete the Statement of Accountability.) If "No," Primary Spoken Language: _____ Primary Written Language: _____	
Did you complete this application? ☐ Yes ☐ No (If "No", you must complete the Statement of Accountability.)	
Statement of Accountability – Must be completed if the applicant answered "No" to read or write English or the applicant did not complete this application. I _____, acting as (describe your relationship) _____ have personally read this form to the applicant and completed the application because: ☐ Applicant does not have sufficient command of the English language to complete this application ☐ Applicant is legally incapacitated and unable to complete this application I have read and explained in detail the contents of this application. _____ If translated, I also fully explained to the applicant the "Authorization to Disclose Personal Health Information" and "Signature(s) Required" under **Sections F and H**.	
Signature of Representative ***(Required)***	Today's Date ***(Required)***
Print Name	
Street Address	

City	State	ZIP Code	Telephone Number ( )

Primary Applicant's Name

Section F – Authorization to Use and Disclose Protected Health Information

Please read the following carefully before completing your authorization. You may refuse to sign this authorization.

Purposes of this Authorization Form
By signing this form, I authorize Aetna, or Aetna's representatives, to pay a fee to a third party for certain protected health information (PHI) about me, including but not limited to, prescribed medication history or other pharmaceutical information, hospital records, physician and/or dentist records, claims or benefit records or lab results. The PHI purchased by Aetna may be used for the following purposes: a) to coordinate medical care and case management, and/or b) for risk adjustment activities.

PHI purchased by Aetna may be related to chronic diseases, mental illness, alcohol or substance abuse, Human Immunodeficiency Virus (HIV) infection, or Acquired Immune Deficiency Syndrome (AIDS).

I authorize Aetna to disclose my PHI for the purposes stated above to other persons or organizations performing services on Aetna's behalf.

Aetna may not condition your treatment, payment, enrollment or eligibility for benefits, on whether or not you sign this authorization.

Health information received by Aetna will not be re-disclosed without your authorization unless permitted by law, as described in Aetna's Notice of Privacy Practices. Information that is re-disclosed may not be protected under federal privacy laws.

Term of Authorization
I agree this Authorization shall be valid for twenty-four (24) months from the signature date below.

Right to Revoke
I understand that I may revoke this authorization at any time by giving written notice to Aetna using the address provided in Section J. My revocation will not have any effect on actions Aetna has already taken before receiving my notice.

Primary Applicant's or Parent/Guardian's Signature	Date
Spouse / Domestic Partner's Signature	Date
Dependent's signature (age 18 or older)	Date
Dependent's signature (age 18 or older)	Date

Primary Applicant's Name

Section G – Payment Options (Select the method of payment for your initial application and following premium payments.)

Initial Payment

- ☐ Easy Pay – Electronic Check (complete the EFT information below)
- ☐ Credit Card (complete the credit card information below)

Recurring or Follow Up Payments

- ☐ Easy Pay (complete the EFT information below)
- ☐ Monthly Billing Statement

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 application signature in **Section H**, I am accepting the terms of the Easy Pay Agreement.

Any rate adjustment made in accordance with the enrollment process will be automatically charged to your account upon approval of your application *prior to the effective date.* Please be advised that tobacco use may result in an increase to 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 (**Section H**) 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 application *prior to the effective date*. You must elect EFT or monthly billing (check or money order) for your next premium payment.

Any rate adjustment made in accordance with the enrollment process will be automatically charged to your account. **Please be advised that tobacco use may result in an increase to the standard premium.**

Primary Applicant's Name

Section H – Signature(s) Required – All Applicants (Primary/Spouse and dependents) age 18 and older must read and sign this form below.

By signing this form you agree to the following:

1. The answers in this application are true and complete to the best of my knowledge and belief.
2. The children listed on this application are my legal dependents.
3. I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by Aetna, and may face legal liability, including legal action based on fraud.
4. I have read this entire application, or it has been read to me.
5. The information I have provided in this application will be used by Aetna to determine whether to issue coverage and the premium amount for such coverage.
6. No coverage shall be in force until Aetna processes this application and Aetna has notified me of my effective date.
7. This application will become part of the contract between Aetna and me.
8. I or my legal representative has the right to receive a copy of this application upon request. I agree that a photocopy shall be as valid as the original. A legal facsimile signature shall have the same force and effect as the original.
9. I authorize Aetna to electronically transmit the information contained in this application.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Primary Applicant's or Parent/Guardian's Signature	Date
Spouse / Domestic Partner's Signature	Date
Dependent's signature (age 18 or older)	Date
Dependent's signature (age 18 or older)	Date

Primary Applicant's Name

Section I – Insurance Producer or Agent (Required If Applicable)

Complete if Broker of Record is an Individual Producer (not an Agency)

Print Name of Producer	NPN of Agent	
To the best of my knowledge, the information on this application is complete and accurate.		
Signature of Producer (required if applicable)		
E-mail Address	Telephone Number ( )	Fax Number ( )
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)		

Complete if Broker of Record is an Agency

Name of Agency HEALTHPLANONE, LLC	TIN of Agency 20-4098658	
E-mail Address SALES@HEALTHPLANONE.COM	Telephone Number (8 7 7) 5 6 7 - 5 2 6 7	Fax Number (8 8 8) 812-6887
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code) 35 NUTMEG DRIVE SUITE 220 TRUMBULL, CT 06611		
Print Name of Producer Representing Agency WILLIAM C. STAPLETON	NPN Number 8577379	
To the best of my knowledge, the information on this application is complete and accurate.		
Signature of Agency Representative (required if applicable)		

General Agent

Print Name of General Agent HEALTHPLANONE, LLC	TIN of General Agent 20-4098658
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code) 35 NUTMEG DRIVE SUITE 220 TRUMBULL, CT 06611	

Aetna Sales Representative

To the best of my knowledge, the information on this application is complete and accurate.		
Last Name of Agent (Print Name)	First Name of Agent (Print Name)	License Number

Section J – Contact Information

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

Aetna Individual Plans
PO Box 730
Blue Bell, PA 19422

Phone #: 866-565-1236
Fax #: 860-975-1253
Website for information: http://www.aetna.com/individuals-families.html

Primary Applicant's Name

Section K – Notice to Applicant Regarding Replacement of Health Insurance

You must complete the below notice if you are currently covered by accident and sickness insurance and this plan is intended to replace your current coverage as noted in Section E of your application.

According to your application (the information furnished by you), you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by _____ Insurance Company. For your own information and protection, certain facts should be pointed out to you which should be considered before you make this change.

1. Health conditions which you may presently have may not be covered under the new policy. This could result in a claim for benefits being denied which may have been payable under your present policy.
2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.
3. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.
4. The new policy will be issued at a higher age than that used for issuance of your present policy; therefore, the cost of the new policy depending upon the benefits may be higher than you are paying for you present policy.
5. The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.
6. It may be to your advantage to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. You should be certain that you understand all the relevant factors involved in replacing your present coverage.
7. WHERE YOUR POLICY HAS BEEN PURCHASED BY MAIL YOU ARE CONSIDERED THE APPLICANT. PLEASE SIGN WHERE DESIGNATED AFTER READING SO THAT THE COMPANY MAY ISSUE YOUR POLICY.

The above "Notice to Applicant" was delivered to me on _____.
(Date)

_____
Applicant

Where solicited by agent, agent should also sign.

_____
Agent