



# Aetna Advantage Plans for Individuals, Families and Self Employed\* – HMO\*\* and PPO\*\*\* – PA

Applicant's Social Security Number

Enrollment Form ID Number

**Instructions:**

- Enrollment Form must be completed by the Applicant in blue or black ink. Please PRINT clearly. (A photocopy of this enrollment form will not be accepted.)
- This enrollment form must be completed in its entirety and one (1) form of payment selected or processing time will be delayed.
- Signature and date is required on Page 4, Section I and Page 5, Section K for all Applicants including spouse and children age 18 and over.
- PPO products are underwritten by Aetna Life Insurance Company through a blanket trust arrangement in Delaware.

\*\* The HMO product is directly underwritten by Aetna Health Inc.

\*\*\* The PPO product is underwritten by Aetna Life Insurance Company through a blanket trust arrangement in Delaware.

[ Send completed enrollment form to:  
Aetna Advantage Plans  
PO Box 14015  
Lexington, KY 40512-4015 ]

**A. Applicant Information**

Name	Maiden Name of Applicant/Spouse	[ Choose desired benefit plan type: <input type="checkbox"/> HMO 20 <input type="checkbox"/> HMO 30 <input type="checkbox"/> HMO 1500 <input type="checkbox"/> HMO 2500 <input type="checkbox"/> HMO 5000 <input type="checkbox"/> First Dollar PPO 25 <input type="checkbox"/> First Dollar PPO 35 <input type="checkbox"/> PPO 1500 <input type="checkbox"/> PPO 2500 <input type="checkbox"/> PPO 5000 <input type="checkbox"/> PPO Value 1500 <input type="checkbox"/> PPO Value 2500 <input type="checkbox"/> PPO 750 with Medical \$50K CYM <input type="checkbox"/> PPO 1500 with Medical \$50K CYM <input type="checkbox"/> PPO 2500 with Medical \$50K CYM <input type="checkbox"/> PPO 7500 with Unlimited Primary Care Visits plus Dental <input type="checkbox"/> High Deductible 3000 (HSA Compatible) <input type="checkbox"/> High Deductible 5000 (HSA Compatible) <input type="checkbox"/> Preventive and Hospital Care 1250 <input type="checkbox"/> Preventive and Hospital Care 3000 <input type="checkbox"/> Dental (Dental option available only with choice of medical plan above.)
Mailing Address (All Aetna correspondence will be sent to this address) - Include Apartment Number, if applicable. Number, Street _____ County _____ City, State, ZIP Code _____	Telephone Numbers Home (    ) Work (    ) Cell (    )	
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 _____	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	(If any PPO plan type is checked, please fill out the "Joinder Agreement" – Section I, Page 4.)
Please check if applicable: <input type="checkbox"/> I am eligible for health benefits offered by my employer <input type="checkbox"/> I am a sole proprietor or I am self-employed	Occupation	
E-mail Address		Reason for Enrollment Form: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Add Spouse/Dependent Child to an Existing Plan <input type="checkbox"/> Add Dependent Child to an Existing Plan <input type="checkbox"/> Change Existing Benefit Plan <input type="checkbox"/> Request for Rate Review
Do you read and write English? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is any person listed on this enrollment form a "non-citizen resident" of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes," has that person(s) resided within the United States for the past six (6) consecutive months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "No," provide the name(s) and explanation.		

**B. Individuals Covered (Dependent children are covered up to age 24.)**

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)	Primary Office ID#**	Previously Seen
APP	Applicant										<input type="checkbox"/> Yes <input type="checkbox"/> No
SP	Spouse										<input type="checkbox"/> Yes <input type="checkbox"/> No
01	Dependent										<input type="checkbox"/> Yes <input type="checkbox"/> No
02	Dependent										<input type="checkbox"/> Yes <input type="checkbox"/> No
03	Dependent										<input type="checkbox"/> Yes <input type="checkbox"/> No

\*\* If you choose an HMO product, visit our website ([www.aetna.com/docFind/custom/advplans/](http://www.aetna.com/docFind/custom/advplans/)) to view participating Pennsylvania Primary Care Physician(s). You may also request a paper directory.

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

Do you currently have any health care coverage?  Yes     No                      Are your spouse/children covered also?  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 an Aetna Plan?  Yes     No  
If "Yes," provide names and relationship: \_\_\_\_\_ ID No. \_\_\_\_\_

Has any Applicant listed on this enrollment form ever been declined, postponed, had a waiver applied or charged an additional premium for life, disability or health insurance or had such insurance rescinded?  Yes     No                      If "Yes," provide the following information:  
Applicant Name: \_\_\_\_\_ Explain: \_\_\_\_\_

Has any Applicant 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 \_\_\_\_\_

Applicants who are currently covered by another carrier must agree to discontinue the other coverage prior to or on the effective date of the Aetna Advantage Plan.  Yes     No  
If "No," explain: \_\_\_\_\_

Are any Applicants listed above eligible for Medicare?  Yes     No  
Applicant Name: \_\_\_\_\_ Applicant Name: \_\_\_\_\_

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



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

Answer all questions & provide complete details to all "Yes" answers on Page 3, Section F.		Missing information may delay processing this enrollment form.
In the past five (5) 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: <i>Eyes/sight:</i> glaucoma, cataracts, crossed eyes, detached retina, corneal transplant, infections; <i>Ears/Hearing:</i> loss of hearing, deafness, infections, eustachian tube dysfunction; <i>Nose/breathing:</i> deviated septum, polyps, adenoiditis, sinusitis, <i>Throat/Swallowing:</i> tonsillitis, strep throat, excessive snoring or sleep apnea, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D2.	Skin Conditions/Disorders: Acne, birthmarks, dermatitis, eczema, fungal infections, psoriasis, keratosis, warts, moles, pre-cancerous lesions, skin cancer or melanoma, 2nd or 3rd degree burns, herpes, scars/keloid, or revisions or cosmetic or reconstructive surgery, excessive sweating, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D3.	Musculoskeletal Conditions/Disorders: Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as strain/sprain, fracture, arthritis, fibromyalgia, gout, herniated disc, joint replacement, internal/external fixations, permanent hardware, amputation/prosthesis, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D4.	Respiratory Conditions/Disorders: Allergies, sinusitis, bronchitis, asthma, pneumonia, shortness of breath, chronic cough, collapsed lung, emphysema, COPD, tuberculosis, fungal infections, difficulty breathing, spitting/coughing up blood, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D5.	Digestive Conditions/Disorders: Infections of mouth/throat/tonsils, problems with jaw or chewing, ulcers, hernia, gastric reflux, 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, unexplained weight loss or gain, eating disorder, Gastric Bypass/Banding, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D6.	Urinary Conditions/Disorders: Bladder infections, kidney infections, stones blood in urine, stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D7.	Heart and Circulatory Conditions/Disorders: Anemia, bleeding/clotting disorders, Hemophilia, thrombocytopenia, varicose/spider veins, Raynauds, phlebitis, thrombosis, enlarged lymph nodes or lymphadenitis, chest pain, angina, high/low blood pressure, hypertension, high cholesterol/lipids, heart murmur, palpitations, congestive heart failure, coronary artery disease, aneurysm, heart attack, bypass surgery/angioplasty, valve replacement, pacemaker or defibrillator, rheumatic fever, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D8.	Metabolic and Endocrine Conditions/Disorders: Diabetes, adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis, thyroid disorders, AIDS/ARC or other immune disorders (not including HIV), etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D9.	Brain/Nervous System Conditions/Disorders: Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, confusion, memory loss, Alzheimer's, dementia, head injury, stroke, migraine or chronic/severe headaches, narcolepsy, sleep apnea, tremors, Multiple Sclerosis, seizures/epilepsy, Muscular Dystrophy and Reflex Sympathetic Dystrophy (RSD), etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D10.	Male Reproductive Conditions/Disorders: Fertility/infertility, low sperm count, sexual dysfunction, erectile dysfunction, enlarged prostate, prostatitis, undescended testes, genital or anal herpes/warts or sexually transmitted diseases, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D11.	Female Reproductive Conditions/Disorders: a) Pelvic pain, abnormal, menstrual bleeding, absence of menstruation, abnormal PAP smear, endometriosis, ovarian cysts, uterine fibroids, fertility/infertility, miscarriage, breast cysts/lumps/fibroids, breast implants, genital warts/herpes or sexually transmitted diseases, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	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: Applicant Name: _____ Reason: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c) Has any <i>female</i> had an abnormal PAP Smear? If "Yes," provide details in F1. Date of last normal PAP Smear: _____ Applicant Name: _____ Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d) Is any <i>female</i> Applicant pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate? If "Yes," provide Applicant name below: Applicant Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
D12.	Nervous, Mental and Behavioral: Depression, anxiety, attention deficit, chemical imbalance, bi-polar, obsessive-compulsive or panic disorders, substance abuse, eating disorders, counseling or support group, alcohol or chemical dependence, anorexia/bulimia, schizophrenia, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D13.	Cancer/Tumors: Cysts, tumors or abnormal growths, Hodgkin's disease, leukemia or any other cancer or malignancy, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D14.	Birth Defects/Congenital Abnormalities: Birthmarks, cleft palate/lip, club foot, webbed fingers/toes, developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation, skull /facial or other physical deformities, Cerebral Palsy, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D15.	Other Conditions: Has any Applicant been diagnosed by or received treatment from any doctor or other health care provider for any other condition not listed on this enrollment form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
NOTE: Medical conditions that occur after the signature date and before the effective date of the coverage if approved will be considered in the final underwriting decision. You shall communicate any medical condition occurring during such period.		

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

<b>Answer all questions &amp; provide complete details to all "Yes" answers on Section F below. Missing information may delay processing this enrollment form.</b>		
E1.	Is any <i>male</i> Applicant expecting a child or in the process of adoption or surrogacy with anyone whether or not that person is enrolling for coverage on this enrollment form? If "Yes," provide Applicant name below. Applicant Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
E2.	Within the past five (5) years, has any Applicant been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? If "Yes," provide Applicant name and date below. Applicant Name: _____ Date Discontinued: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
E3.	Within the past five (5) years, has any Applicant ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal or controlled IV drugs? Applicant Name: _____ Type of Drug/Substance: _____ Date Discontinued: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
E4.	Within the past five (5) years, has any Applicant consumed any alcoholic beverage? (Amount: A drink is 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor.) Applicant Name: _____ Type: _____ Amount: _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No
E5.	Within the past five (5) years, has any Applicant been convicted of a DUI (drunk driving violation)? If "Yes," provide Applicant name(s), state(s) and date(s). Applicant Name: _____ State: _____ Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
E6.	Has any Applicant 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E7.	Within the past five (5) years, has any Applicant 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E8.	Within the past five (5) years, has any Applicant been medically advised to undergo further medical testing, treatment or surgery which has not yet been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E9.	Within the past five (5) years, has any Applicant been a patient in an outpatient clinic, hospital, surgical center, treatment center or other medical facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E10.	Within the past five (5) years, has any Applicant been diagnosed by or received treatment from any doctor or health care provider for any other condition not listed on this enrollment form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E11.	Within the past five (5) years, has any Applicant smoked or used tobacco product, such as Snuff and/or chewing tobacco. If "Yes," provide Applicant(s) below. Applicant Name: _____ Date Stopped: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
E12.	Within the past five (5) years, has any Applicant taken prescription medications or been advised to take prescription medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E13.	Within the past five (5) years, has any Applicant ever seen, received treatment from or consulted any health care provider for any other condition not listed on this enrollment form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E14.	Is any Applicant a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E15.	Is any Applicant currently on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**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		Explain Nature of Illness/Condition	Describe Treatment Received/Recommended and Any Limitations if Applicable
		From	To		

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

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

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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 dependents consulted. If None, please state "None."

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

4. List 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					
01					
02					
03					

**G. 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 or the  15th of \_\_\_\_\_ (month).  
 You will be given the requested effective date if Aetna approves the enrollment form within 30 days. This date must be no later than 90 days after the signature date (Page 5, Section K) of this enrollment form. This date will be honored provided that Aetna's approval is within 30 days of the requested effective date. No requested effective date will be honored prior to or on the signature date.

**H. Statement of Enrollment Conditions**

Each member of the family will be medically underwritten separately and assigned a separate medical coverage based on their 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.

**I. 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 a 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 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/Parent or Legal Guardian Signature	Today's Date
Applicant Spouse (If enrolling for coverage)	Today's Date
Applicant's Dependent (Not a minor)	Today's Date

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**J. 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 enrolling for this coverage, I on behalf of myself and the dependents listed on this Enrollment Form, 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 subject to the Grace Period. If you are terminated for nonpayment of premium, you may no longer be eligible to enroll in any of Aetna's Plans. I agree to make co-payments and any other contributions, as provided for in my plan documents, directly to providers of health care.
3. For HMO Plans only: As a condition of coverage, I understand and agree that (with the exception of emergency procedures and certain direct access services as defined in the plan documents) all services, in order to be covered by Aetna, must be performed either by a participating primary care physician, or by the participating specialist, hospital, pharmacy (if applicable) or other provider as authorized by a referral from a participating primary care physician.\*  
*\*Some services may require prior authorization from Aetna*
4. I authorize Aetna to request my and/or my dependents' (those who are enrolling for coverage under this enrollment form) medical records, any prescribed medication history and any other medical or pharmaceutical information to process my enrollment form and to make a decision on the approval or disapproval of my and/or my dependents' enrollment form. I authorized 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 me or any of my dependents enrolling for coverage under this enrollment form to disclose the information required by Aetna and described above to Aetna and/or its designated agents.  
 The existence of such information and documentation as described above shall be disclosed under this Enrollment Form. 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 Applicants; 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 further authorize Aetna to use such information and to disclose such information to affiliates, Providers, payors, 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.  
 I have discussed the terms of this authorization with my spouse and competent adult dependents, and I have obtained their consent to those terms. I understand that this authorization is provided under state law and regulations. This authorization will remain valid for the term of the coverage and if so long thereafter as allowed by law. This authorization may be revoked by me at any time by completing the form entitled "Revocation of Authorization Previously Given to Aetna" available by calling the member service number on my ID card. I understand that Aetna will comply with the HIPAA Privacy Rules and that disclosure of information will be done under the rules of such Federal law.  
 I understand and agree that Aetna will use any information supplied in this Enrollment Form prior to the effective date of coverage in considering my enrollment form, including any medical information.  
 I understand that I am entitled to receive a copy of this authorization upon request, and that a photocopy is as valid as the original
5. I have an obligation of communicating to Aetna in writing any medical conditions which occur to myself or to any of my dependents listed in this Enrollment Form after the signature of this Enrollment Form and before the effective date of the coverage if approved.
6. I understand and agree that, with the exception of Aetna Rx Home Delivery, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
7. Information on agent's compensation is available from your agent or at Aetna.com.
8. 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 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.

**K. Signature(s) Required - All Applicants age 18 or older must sign and date below.**

**If Applicant is a minor, the enrollment form must be signed by a parent or legal guardian.**

I represent that all information supplied on this form is true, complete, and correctly recorded by me. I have myself read, understand, and agree to the conditions of enrollment on this Enrollment form. I understand that the information supplied in this form will be decisive for the approval of my enrollment and that fraud, or any material misrepresentation will be reason for cancellation/termination of the coverage for which I am enrolling. I UNDERSTAND THAT IF MY SIGNATURE/DATE DO NOT APPEAR AND/OR ARE NOT CURRENT AND/OR MY ANSWERS ARE INCOMPLETE, my enrollment will be declined.

Once you submit this enrollment form, you may be contacted at any time via telephone by an Aetna representative to complete your enrollment and the underwriting process. You will be able to confirm the identity of the person calling. Please do not answer any questions if you are not satisfied with the identity of the caller. The person calling will give you a number to confirm their identity. Please call if you have any doubts or problems with respect to the call or the process during the call.

Applicant/Parent or Legal Guardian Signature	Today's Date	Applicant/Spouse (If enrolling for coverage)	Today's Date
Applicant's Dependent Age 18 or Older Signature	Today's Date	Applicant's Dependent Age 18 or Older Signature	Today's Date

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**L. Important Applicant Information** Please Read Carefully

- Coverage may be declined, or a premium adjustment made, based on information provided to Aetna during the enrollment process. In the case of declination, you will receive a letter notifying you that your enrollment has not been accepted. Specific details will be kept confidential. If all members on the enrollment form are declined coverage, the original check will be returned directly to the Applicant.
- Do *not* cancel other coverage presently in force until written notification is received from Aetna indicating that your enrollment has been approved and you and covered dependents are in receipt of your member ID card(s) providing the effective date of coverage.

**PAYMENT OPTIONS - Please select the method of payment for your initial application and subsequent premium payments**

**M. Initial Payment**

- Easy Pay (complete the EFT information below)
- Credit Card (complete the credit card information below)
- Personal Check or Money Order (make payable to "Aetna" and attach to your completed application)

**N. 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: \_\_\_\_\_



Routing Number    Account Number    Check Number

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 EFT box above and with my enrollment form signature on Page 5, Section K, 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 5, Section K) even if not applying.

**Credit Card Payment Option**

Credit Card Type <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard	Cardholder's Name (exactly as it appears on the card)
Account Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	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.

**O. Statement of Accountability - To be completed if the Applicant cannot or has not completed the enrollment form.**

I, \_\_\_\_\_, personally read and completed the Individual Enrollment form for the Applicant named below because:  Applicant does not read English     Applicant does not speak English     Applicant does not write English  
 Other (explain): \_\_\_\_\_

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by: \_\_\_\_\_

I also translated and fully explained the "Conditions and Agreement."

Signature of Translator (Required) \_\_\_\_\_ Today's Date (Required) \_\_\_\_\_  
 Relationship to Applicant \_\_\_\_\_

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**P. Insurance Producer Information (If applicable)**

1. Are you aware of any information not disclosed on this enrollment form relating to the health, habits or reputation of any person listed on this enrollment form which might have a bearing on the risk? If "Yes," please attach explanation.		General Agent <input type="checkbox"/> Yes <input type="checkbox"/> No		Insurance Broker <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Did you see the proposed applicant at the time this application was executed? If "No," please explain:		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Signature of Insurance Producer (Required if applicable)			Signature of General Agent (Required if applicable)		
Date	E-mail Address		Date	E-mail Address	
Name of Insurance Producer or Agency to be assigned as Broker of Record (print name)			Name of General Agent (print name)		
TIN of Producer or Agency to be assigned as Broker of Record			Agent TIN Number		
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)			Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)		
Telephone Number ( )	Fax Number ( )		Telephone Number ( )	Fax Number ( )	

**Q. Aetna Sales Representative**

Last Name of Sales Representative (print name)	First Name of Sales Representative (print name)
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**R. Instructions**

Please review these instructions.

- The Applicant must complete the enrollment form. You are responsible to ensure that the information on the enrollment form is correct, complete, and truthful.
- Print clearly using blue or black ink. No pencil or correction fluid, please.
- This enrollment form must be received by Aetna's Medical Underwriting team within thirty (30) days from the signature date.
- Any misrepresentation of information on the enrollment form may result in cancellation of coverage.
- Your insurance will become effective only if this enrollment form is approved as enrolled for and the appropriate premium is enclosed.  
*You are ineligible for coverage if as a non-citizen Applicant you have not resided in the U.S. for the last six (6) consecutive months.*

Coverage is not guaranteed until approved in writing by Aetna. Do not cancel your current insurance coverage until you have been notified of approval by Aetna and your Aetna coverage is effective.

**S. Effective Date**

Dates are assigned to the 1st and 15th of the month. If not selected, underwriting will assign the first available date.  
To avoid delays in underwriting, please review for:

- Missing or incomplete information such as:
  - Weight AND Height
  - Date of birth
  - Physician address and telephone number
- Incomplete mailing address information including city, state, and ZIP code.
- Incomplete answers to all enrollment form sections. If a Health Question does not apply to you, the answer should be "No."
- If additional information or explanation is necessary attach extra sheets. All attachments must be signed and dated.
- If the Applicant chooses a PPO product, complete the Joinder agreement section.

**T. Payment Options**

Carefully read the instructions accompanying each payment option (Page 6, Sections M, and N).

**U. Contact Information**

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

Aetna Advantage Plans PO Box 14015 Lexington, KY 40512-4015	Fax #: 866-892-8396 <a href="http://www.aetna.com/members/individuals">www.aetna.com/members/individuals</a> ]
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