



Aetna Advantage Plans for Individuals, Families and Self-Employed* - TX

Applicant's Social Security Number

Application ID Number

** You have the option to choose this Consumer Choice of Benefits Health Insurance Plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. This standard health benefit plan may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy.

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

Instructions:

- Application must be completed by the Applicant in blue or black ink. **Please PRINT clearly. (A photocopy of this application will not be accepted.)**
- **This application 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 6, Section L** for all applicants including spouse and children age 18 and over.
- PPO products are underwritten by Aetna Life Insurance Company.

A. Applicant Information

		Aetna Use Only Y - N - U	Effective Date:	Number:
Name		Maiden Name of Applicant/Spouse		
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 () _____	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner Occupation _____ Do you read and write English? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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 _____		E-mail Address _____		
Is any person listed on this Application a “non-citizen resident” of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No		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		
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		Reason for Application: <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		
If “No”, provide the name(s) and explanation.				

[Choose desired benefit plan type:

PPO:

<input type="checkbox"/> PPO 2500**	<input type="checkbox"/> PPO 3500**	<input type="checkbox"/> PPO 5000**	<input type="checkbox"/> PPO 7500**	<input type="checkbox"/> First Dollar PPO 30	<input type="checkbox"/> First Dollar PPO 40**
<input type="checkbox"/> PPO Value 1500**	<input type="checkbox"/> PPO Value 2500**	<input type="checkbox"/> PPO Value 5000**			
<input type="checkbox"/> High Deductible PPO 3000 (HSA Compatible)	<input type="checkbox"/> High Deductible PPO 5000 (HSA Compatible)**				
<input type="checkbox"/> Preventive and Hospital Care 1250	<input type="checkbox"/> Preventive and Hospital Care 3000 (HSA Compatible)**				
<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**			

Managed Choice Open Access (MCOA):

<input type="checkbox"/> MCOA 2500**	<input type="checkbox"/> MCOA 3500**	<input type="checkbox"/> MCOA 5000**	<input type="checkbox"/> MCOA 7500**	<input type="checkbox"/> First Dollar MCOA 30	<input type="checkbox"/> First Dollar MCOA 40**
<input type="checkbox"/> MCOA Value 1500**	<input type="checkbox"/> MCOA Value 2500**	<input type="checkbox"/> MCOA Value 5000**			
<input type="checkbox"/> High Deductible MCOA 3000 (HSA Compatible)	<input type="checkbox"/> High Deductible MCOA 5000 (HSA Compatible)**				
<input type="checkbox"/> Preventive and Hospital Care 1250	<input type="checkbox"/> Preventive and Hospital Care 3000 (HSA Compatible)**				
<input type="checkbox"/> MCOA 750 with Medical \$50K CYM**	<input type="checkbox"/> MCOA 1500 with Medical \$50K CYM**	<input type="checkbox"/> MCOA 2500 with Medical \$50K CYM**			

Dental (Dental option available only with choice of medical plan above.)]

B. Individuals Covered (Dependent children are covered to age 25.)

Check here if more space is needed to provide information on additional dependents. Use a separate sheet of paper and staple to the back of this application.

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

*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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C. Dependent Information

Do you claim that all children listed above who are between the ages of 19 to age 25 are unmarried?
 Yes No

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

Are you replacing existing coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are your spouse/children covered also? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are any family members listed above currently enrolled in an Aetna Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes," provide names and relationship: _____ ID#: _____	
Provide name of current (or most recent) health care carrier and coverage termination date (if applicable). Name: _____ Term Date: _____	
Has any applicant ever filed a claim and/or received benefits from disability insurance or Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes" provide the following information: Applicant Name: _____ Date: _____ Explanation: _____	

E. Health History for Individual and Their Dependents (Include information for all persons applying for coverage.)

Answer all questions & provide complete details to all "Yes" answers on Page 4, Section G. Missing information may delay processing this application.

In the past ten (10) years, has any person listed on this application had any signs or symptoms that would cause an ordinary prudent person to seek advice or treatment or had treatment or consultation recommended, received treatment from a health care provider (including prescription medications) or been hospitalized for any of the following conditions or diseases listed in Sections E and F?

E1.	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
E2.	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 of cosmetic or reconstructive surgery, excessive sweating, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E3.	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
E4.	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
E5.	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 gallbladder, hepatitis A/B/C/other, Cirrhosis, jaundice, unexplained weight loss or gain, eating disorder, Gastric Bypass/Banding, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E6.	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
E7.	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
E8.	Metabolic and Endocrine Conditions/Disorders: Diabetes, adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis, thyroid disorders, or other immune disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E9.	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, Reflex Sympathetic Dystrophy (RSD), etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E10.	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

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E. Health History for Individual and Their Dependents (Continued)

E11.	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 female had an abnormal PAP Smear? If "Yes," provide details in G1. Date of last normal PAP Smear. Applicant Name: _____ Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d) Is any female 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
E12.	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
E13.	Cancer/Tumors: Cysts, tumors or abnormal growths, Hodgkin's disease, leukemia or any other cancer or malignancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E14.	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
E15.	Other Conditions: Has any applicant consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s) not listed on this application?	<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 should communicate any medical condition occurring during such period.

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

Answer all questions & provide complete details to all "Yes" answers on Page 4, Section G. Missing information may delay processing this application.		
F1.	Is any male applicant expecting a child or in the process of adoption or surrogacy with anyone whether or not that person is applying for coverage on this application? If "Yes," provide applicant name below. Applicant Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
F2.	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(s) and date(s) below. Applicant Name: _____ Date Discontinued: _____ Applicant Name: _____ Date Discontinued: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
F3.	Has any applicant ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal, or controlled IV drugs? If "Yes," provide applicant name(s) below. Applicant Name: _____ Type of Drug/Substance: _____ Date Discontinued: _____ Applicant Name: _____ Type of Drug/Substance: _____ Date Discontinued: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
F4.	Has any applicant 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.) Applicant Name: _____ Type: _____ Amount: _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month Applicant Name: _____ Type: _____ Amount: _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No
F5.	Has any applicant been convicted of a DUI (drunk driving violation)? If "Yes," provide applicant name(s), state(s) and dates. Applicant Name: _____ State: _____ Date: _____ Applicant Name: _____ State: _____ Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
F6.	Has any applicant been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS-Related Complex) or tested positive for HIV (Human Immunodeficiency Virus)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F7.	Has any applicant had any abnormal lab results, X-rays, MRI or other diagnostic test results or physical exam results?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F8.	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
F9.	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

continued

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F. Health Related Questions (Continued)

F10.	Has any applicant seen any health care provider for any condition, signs, or symptoms which have not yet been diagnosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F11.	Has any applicant smoked or used any tobacco products, such as snuff and/or chewing tobacco, in the last 2 years? If "Yes," provide applicant name(s) below. Applicant Name: _____ Date Stopped: _____ Applicant Name: _____ Date Stopped: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
F12.	Has any applicant taken prescription medications or been advised to take prescription medications in the last 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F13.	Has any applicant ever seen, received treatment from, or consulted any health care provider for any other condition or symptom(s) not listed on this application?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F14.	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
F15.	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

G. Detailed Health Information

Check here if additional space is needed. Use a separate sheet of paper and staple to the back of this application.

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

Family Code*	Ques. No.	Dates		Explain Nature of Illness/Condition	Describe Treatment Received/Recommended and Any Limitations if Applicable	Do you consider yourself fully recovered
		From	To			
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

2. List all prescription medications and/or doctors' 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

continued

*See Page 1, Section B.

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G. 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					

*See Page 1, Section B.

H. 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	<input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian– 04 <input type="checkbox"/> Other – 05 _____
APP	<input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian– 04 <input type="checkbox"/> Other – 05 _____	02	<input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian– 04 <input type="checkbox"/> Other – 05 _____
SP	<input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian– 04 <input type="checkbox"/> Other – 05 _____	03	<input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian– 04 <input type="checkbox"/> Other – 05 _____

I. 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 application via email.

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

If Aetna approves my application, 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 application within 30 days. This date must be no later than 90 days after the signature date (Page 6, Section L) of this application. 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.

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K. Conditions and Agreement - Please Read Before Signing Below.

IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN. By filing this application and applying for this coverage, I on behalf of myself and the dependents listed on this Application, agree to or with the following:

1. Aetna may decline this application. No coverage comes into effect until Aetna approves this application.
2. Coverage and benefits, once they come into effect, are contingent on timely and accurate payment of premiums and any other cost sharing as outlined in the policy. If payment of premiums are not paid on time and accurately, subject to the terms and conditions of the Grace Period, your coverage will be terminated. If you are terminated for non payment 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 cost sharing as provided for in my policy, directly to providers of health care.
3. I authorize Aetna to request my and/or my dependents' (those who are applying for coverage under this application) medical records, any prescribed medication history and any other medical or pharmaceutical information to process my application and to make a decision on the approval or disapproval of my and/or my dependents' application. 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 me or any of my dependents applying for coverage under this application 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 Application. I understand that Aetna will rely on such information to: 1) underwrite this application 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. 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 Application prior to the effective date of coverage in considering my application, 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.
4. 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 Application after the signature of this Application and before the effective date of the coverage if approved.
5. I understand and agree that, with the exception of Aetna Rx Home Delivery, all participating providers and vendors are independent contractors and are neither insurance producers 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.
6. Information on agent's compensation is available from your agent or at Aetna.com.
7. Any person who knowingly or willfully makes a false or fraudulent statement or representation in or with reference to an application for insurance may be guilty of insurance fraud.

**L. Signature(s) Required - All applicants age 18 and over must sign and date below.
 If applicant is a minor, the application 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 Application. I understand that the information supplied in this form will be decisive for the approval of my application and that any intentional misrepresentation of material fact in such information will be reason for cancellation/termination of the coverage for which I am applying.

I UNDERSTAND THAT IF MY SIGNATURE/DATE DO NOT APPEAR AND/OR ARE NOT CURRENT AND/OR MY ANSWERS ARE INCOMPLETE, my application will be denied.

Once you submit this application, you may be contacted at any time via telephone by an Aetna representative to complete your application 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 Signature (If enrolling for coverage)	Today's Date
Dependent Signature (Not a minor)	Today's Date	Dependent Signature (Not a minor)	Today's Date

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M. [Election of PPO 2500, 3500, 5000, 7500, First Dollar PPO 40, PPO Value 1500, 2500, 5000, PPO High Deductible 5000, and Preventative and Hospital Care 3000, PPO 750 with Medical \$50K CYM , PPO 1500 with Medical \$50K CYM, PPO 2500 with Medical \$50K CYM Election of MCOA 2500, 3500, 5000, 7500, First Dollar MCOA 40, MCOA Value 1500, 2500, 5000, MCOA High Deductible 5000, and Preventative and Hospital Care 3000, MCOA 750 with Medical \$50K CYM, MCOA 1500 with Medical \$50K CYM, MCOA 2500 with Medical \$50K CYM]

By choosing one of the Consumer Choice Benefit plans listed in the title above, you have elected to choose a plan that may provide fewer health benefits than state mandated by Texas.

TEXAS DEPARTMENT OF INSURANCE REQUIRED DISCLOSURE NOTICE FOR ALL INDIVIDUAL INDEMNITY CONSUMER CHOICE BENEFIT PLANS ISSUED IN TEXAS

As required by 28 TAC §21.3530, I have been informed that the Consumer Choice Health Benefit Plan that I am purchasing does not include all state mandated health insurance benefits. I understand that the following benefits are provided at a reduced level from what is mandated, or are excluded completely from the plan:

Mandated Benefit Description	Benefit Reduced	Benefit Excluded
Telemedicine/Telehealth: Article 21.53F Texas Insurance Code Medical services, some of which may be conducted without a face-to-face consultation.		Not covered.
Maternity Benefits: Section 21.404(6), Subchapter E, Title 28 Texas Administration Code.		Not offered. Complications of pregnancy are covered.
Mastectomy Minimum Length of Stay Following Mastectomy or Lymph Node Dissection		Minimum length of stay Article 21.52G, Texas Insurance Code determined by attending physician in consultation with patient. May vary from statutory minimum
Mental/Nervous Disorders With Demonstrable Organic Disease Section 3.3057(d), Exhibit A, Subchapter S, Title 28, Texas Administrative Code		Not covered.
Certain Therapies for Children With Developmental Delays Article 21.53F, Section 9, Texas Insurance Code		Not covered.
HIV, AIDS, or HIV-Related Illnesses: Articles 3.70-3A Texas Insurance Code; Section 3.3057(d), Exhibit A, Subchapter S, Title 28, Texas Administrative Code		Not covered.

I also understand that if I purchase a health plan that excludes or reduces coverage for a certain condition, I may be limiting my ability to obtain individual insurance coverage for that condition, in the event the health of any individual covered under the plan changes. I understand that I may obtain from the Department of Insurance a consumer brochure with more information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at www.tdi.state.tx.us/consumer/indexc.html, or by calling 1-800-252-3439.

NOTE: This form must be retained by the carrier issuing the policy and must be provided to the Commissioner of Insurance upon request. **You have the right to a copy of this written disclosure statement free of charge.** A new form must be completed upon each subsequent renewal of this policy.

By signing this document, I affirm that I was offered a benefit plan that contains the state mandated health insurance benefits and that I have elected to purchase this Consumer Choice Benefit Plan.

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

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N. Important Applicant Information - Please Read Carefully.

- Coverage may be declined, or a premium adjustment made, based on information provided to Aetna during the application process. In the case of declination, you will receive a letter notifying you that your application has not been accepted. Specific details will be kept confidential. If all members on the application are denied 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 application 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.

O. 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)

P. 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 checking the "Yes" box above and with my application signature on **Page 6, Section L**, 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 application. 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 6, Section L**) 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	Card Verification Code* <input type="text"/> <input type="text"/> <input type="text"/>	

Credit card payment is for your initial premium payment only and will be charged upon approval of your application. You must select 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 adjustments may result in an increase of 0% to 100% of the standard premium.

*The Verification Code can be found on the back of your credit card. This 3-digit code is usually the last three digits located in the signature panel.

Q. Statement of Accountability - To be completed if the applicant cannot or has not completed the application.

I, _____, personally read and completed the Individual Application 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: _____

Applicant's Social Security Number									

Application ID Number									

R. Insurance Producer Information (If applicable)

1. Are you aware of any information not disclosed on this application relating to the health, habits, or reputation of any person listed on this application 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	
3. I acknowledge the applicant has received an "Outline of Coverage". 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)			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 or 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 ()	

S. Aetna Sales Representative

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

Please review these instructions.

- The applicant must complete the application. **You are responsible to ensure that the information on the application is correct, complete and truthful.**
 - Print clearly using blue or black ink. No pencil or correction fluid, please.
 - This application must be received by Aetna's Medical Underwriting team within thirty (30) days from the signature date.
 - Any intentional misrepresentation of material fact on the application may result in cancellation of coverage.
 - Your insurance will become effective only if this application is approved as applied 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 by Aetna. Do not cancel your current insurance coverage until you have been notified of approval by Aetna and your Aetna coverage is effective.**

U. 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 phone number
- Incomplete mailing address information including city, state, and ZIP Code.
- Incomplete answers to all application 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.**

V. Payment Options

Carefully read the instructions accompanying each payment option (Page 8, Sections O and P).

[W. Contact Information

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

Aetna Advantage Plans
PO Box 14015 Fax #: 866-892-8396
Lexington, KY 40512-4015 www.aetna.com/members/individuals]

