Aetna Advantage Plans for Individuals and Families - TX

Applicant's Social Security 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.

Instructions:

- Application must be completed by the Applicant in blue or black ink. **(A photocopy of this application will not be accepted.)**
- **This application must be completed in its entirety and first month's premium check payable to Aetna enclosed or processing time will be delayed.**
- Signature and date is required on Page 4, Section J for all applicants including spouse.
- PPO products are underwritten by Aetna Life Insurance Company.
- Any family member currently pregnant (whether or not listed on this application) or in the process of adoption or surrogacy does not qualify for this plan.

Send completed application to:
Aetna Advantage Plans, F230
P.O. Box 61516
King of Prussia, PA 19406-0916

A. Applicant Information

Name

Maiden Name of Applicant/Spouse

Home Address (Required) - Include Apartment Number, if applicable.
Number, Street ______
City, State, ZIP Code ______

Telephone Numbers
Home ( )
Work ( )

Choose desired benefit plan type:
☐ PPO 500 ☐ PPO 5000**
☐ PPO 1500** ☐ High Deductible PPO 1 (HSA Compatible)
☐ PPO 2500** ☐ High Deductible PPO 2 (HSA Compatible)**

Billing Address (if different from your home address above; **Required**) - Include Apartment Number, if applicable.
Number, Street ______
City, State, ZIP Code ______

Please check if applicable:
☐ I am not eligible for health benefits offered by my employer
☐ I am a sole proprietor or I am self-employed

Reason for Application
☐ New Enrollment
☐ Add Spouse/Dependent Child
☐ Add Dependent Child Only
☐ Change Existing Benefit Plan

Marital Status ☐ Single ☐ Married

Occupation

E-mail Address (optional)

Primary Language Spoken (optional)

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

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

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

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

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

If more space is needed to provide information for additional dependents, check here ☐ and use a separate sheet of paper. Please staple to the back of this application.

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? ☐ Yes ☐ No

Do you currently have any health care coverage? ☐ Yes ☐ No

Are your spouse/children covered also? ☐ Yes ☐ No

Has any applicant ever filed a claim and/or received benefits from disability insurance or Workmen's Compensation? ☐ Yes ☐ No
If Yes, provide dates and details.

Are any family members listed above currently enrolled in an Aetna Plan? ☐ Yes ☐ No
If Yes, provide names and relationship. ______

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

Has any applicant listed on this application 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:
Name of Applicant: ______ Explanation: ______

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

If Aetna approves my application, please assign an effective date of the ☐ 1st or the ☐ 15th of ______.
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 4, Section J) of this application. This date will be honored provided that Aetna's approval is within 30 days of the requested effective date. If no effective date is requested, Aetna will assign an effective date of the 1st or the 15th of the month following the approval date of this application. No requested effective date will be honored prior to signature date.

Aetna Use Only
Y - N - U
Effective Date:

This application is not proof of coverage.

Applicant's Social Security Number

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F. Health History for Individuals and Their Dependents *(Include information for all persons applying for coverage.)*

Answer all questions & provide complete details to all "yes" answers on Page 3, Section H. **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 Section F and G?

F1.	**Eyes, Ears, Nose and Throat:** *Eyes/sight:* glaucoma, cataracts, crossed eyes, detached retina, infections; *Ears/Hearing:* loss of hearing, deafness, infections, eustachian tube dysfunction; *Nose/breathing:* deviated septum, polyps, adenoiditis, sinusitis; *Throat/Swallowing:* tonsillitis, strep throat, excessive snoring or sleep apnea, etc?	☐ Yes ☐ No
F2.	**Skin Conditions/Disorders:** Acne, birthmarks, dermatitis, eczema, fungal infections, psoriasis, keratosis, warts, moles, pre-cancerous lesions, skin cancer or melanoma, etc?	☐ Yes ☐ No
F3.	**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?	☐ Yes ☐ No
F4.	**Respiratory Conditions/Disorders:** Allergies, sinusitis, bronchitis, asthma, pneumonia, shortness of breath, chronic cough, pneumothorax, emphysema, COPD, tuberculosis, fungal infections, etc.?	☐ Yes ☐ No
F5.	**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, jaundice, unexplained weight loss or gain, eating disorder, etc.?	☐ Yes ☐ No
F6.	**Urinary Conditions/Disorders:** Bladder infections, kidney infections, stones, blood in urine, stress, incontinence, urinary frequency, painful/ difficult urination, etc.?	☐ Yes ☐ No
F7.	**Heart and Circulatory Conditions/Disorders:** Anemia, bleeding/clotting disorders, 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, etc.?	☐ Yes ☐ No
F8.	**Metabolic and Endocrine Conditions/Disorders:** Diabetes, adrenal/pituitary disorders; lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis; thyroid disorders, and immune disorders?	☐ Yes ☐ No
F9.	**Brain/Nervous System Conditions/Disorders:** Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, confusion, memory loss, Alzheimer's, head injury, stroke; migraine or chronic/severe headaches; narcolepsy, sleep apnea, tremors; multiple sclerosis, etc.?	☐ Yes ☐ No
F10.	**Male Reproductive Conditions/Disorders:** Infertility, low sperm count, sexual dysfunction, erectile dysfuction, enlarged prostate, prostatitis, undescended testes; genital or anal herpes/warts or sexually transmitted diseases, etc.?	☐ Yes ☐ No
F11.	**Female Reproductive Conditions/Disorders:** a) Pelvic pain, abnormal menstrual bleeding, absence of menstruation; abnormal PAP smear, endometriosis, ovarian cysts, uterine fibroids, infertility, miscarriage; breast cysts/lumps/fibroids, breast implants; genital warts/herpes or sexually transmitted diseases, etc.?	☐ Yes ☐ No
	b) Does any proposed ***female*** member menstruate? List Names Name ______________ ☐ Yes ☐ No Name ______________ ☐ Yes ☐ No Name ______________ ☐ Yes ☐ No Name ______________ ☐ Yes ☐ No	
	c) Has it been more than 40 days since any female listed above had her last menstrual period? If Yes, provide name(s) and explain:	☐ Yes ☐ No
	d) Provide the date and result of last Pelvic Exam/Pap Smear for each ***female*** over age 18: (If No Pap done, enter N/A.) Name ______________ Date ________ Result: ☐ Normal ☐ Abnormal ☐ N/A Name ______________ Date ________ Result: ☐ Normal ☐ Abnormal ☐ N/A Name ______________ Date ________ Result: ☐ Normal ☐ Abnormal ☐ N/A Name ______________ Date ________ Result: ☐ Normal ☐ Abnormal ☐ N/A	
	e) Is any ***female*** applicant pregnant or in the process of adoption or becoming a surrogate? If Yes, provide name: Applicant Name ______________	☐ Yes ☐ No
F12.	**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, etc.?	☐ Yes ☐ No
F13.	**Cancer/Tumors:** Cysts, tumors or abnormal growths; Hodgkin's disease, leukemia or any other cancer?	☐ Yes ☐ No
F14.	**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.?	☐ Yes ☐ No
F15.	**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?	☐ Yes ☐ 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.

Applicant's Social Security Number

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

Answer all questions & provide complete details to all "yes" answers on Page 3, Section H. **Missing information may delay processing this application.**

G1.	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 ______	☐ Yes ☐ No
G2.	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) below. Applicant Name ______ Date Discontinued ______ Applicant Name ______ Date Discontinued ______	☐ Yes ☐ No
G3.	Has any applicant ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal or 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 ______	☐ Yes ☐ No
G4.	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 ☐ Day ☐ Week ☐ Month Applicant Name ______ Type ______ Amount ______ per ☐ Day ☐ Week ☐ Month	☐ Yes ☐ No
G5.	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)?	☐ Yes ☐ No
G6.	Has any applicant had any ***abnormal*** lab results, X-rays, MRI or other diagnostic test results or physical exam results?	☐ Yes ☐ No
G7.	Has any applicant been medically advised to undergo further medical testing, treatment or surgery which has not yet been completed?	☐ Yes ☐ No
G8.	Has any applicant been a patient in a clinic, hospital, surgical center, treatment center or other medical facility?	☐ Yes ☐ No
G9.	Has any applicant seen any health care provider for any condition, signs or symptoms which have not yet been diagnosed?	☐ Yes ☐ No
G10.	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 ______	☐ Yes ☐ No
G11.	Has any applicant taken prescription medications or been advised to take prescription medications in the last 2 years?	☐ Yes ☐ No
G12.	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?	☐ Yes ☐ No

H. Detailed Health Information *If additional space is needed, check here ☐ and use a separate sheet of paper. Please staple to the back of this application.*

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

Family Code*	Ques. No.	Dates From/To	Explain Nature of Illness/Condition	Describe Treatment Received/Recommended and Any Limitations if Applicable	% of Recovery

2. List all medications taken by you and/or your named dependents within the last 12 months.

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

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(s)

***See Page 1, Section B.**

Applicant's Social Security Number

H. Detailed Health Information *(Continued)*

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

Family Code*	Purpose of Visit	Date of Visit	Results of Visit		Name, Address and Phone Number of Physician
			Normal	Abnormal: Give Details	
APP					
SP					
01					
02					
03					

*See Page 1, Section B.

I. Conditions and Agreement Please Read Before Signing Below

IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN. By filling 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 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. 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.

J. Signature(s) Required - All applicants over the age of 18 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.

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

Applicant's Social Security Number

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K. Statement of Enrollment Conditions

If one or more family members are not approved, Aetna will enroll the approved family members unless otherwise indicated below:

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

L. Important Applicant Information Please Read Carefully

1. **Send a check payable to "AETNA" for one month's premium with your completed application.**
2. 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.
3. 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.

M. Easy Pay (Electrontic Fund Transfer - EFT)

☐ **Yes**, I would like to use Easy Pay. Checking Account Number: ____________________ Name of Bank: ________________________________

Name(s) on Checking Account: ____

Please include a blank check marked "VOID" showing the preprinted account number in addition to the first month's premium check.

☐ **No**, I do not want to use Easy Pay. Please bill me each month.

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, the 1st of every month. I understand that by checking the "Yes" box above and with my application signature on Page 4 (Section J) I am accepting the terms of the Easy Pay Agreement.

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 4, Section J) even if not applying.

N. 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 ________________________________

O. 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? ☐ Yes ☐ No
   If Yes, please attach explanation.
2. Did you see the proposed applicant at the time this application was executed? ☐ Yes ☐ No
   If No, please explain:
3. I acknowledge the applicant has received an "Outline of Coverage". ☐ Yes ☐ No
   If No, please explain:

Signature of Insurance Producer (*Required*)		Date	E-mail Address
Name of Insurance Producer (print name)	TIN Number	Street Address	Suite No. / Personal Mail Box (PMB) No.
Telephone Number ( )	FAX Number ( )	City / State / ZIP Code	
Signature of General Insurance Producer (*Required, if applicable)*		Date	E-mail Address
Name of General Insurance Producer (print name)	TIN Number	Street Address	Suite No. / Personal Mail Box (PMB) No.
Telephone Number ( )	FAX Number ( )	City / State / ZIP Code	

Applicant's Social Security Number

P. Election of PPO 1500, PPO 2500, PPO 5000 and High Deductible PPO 2 Benefit Plans

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 Article 21.52G, Texas Insurance Code		Minimum length of stay 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** *(If enrolling for coverage)*	Today's Date
Dependent Signature *(not a minor)*	Today's Date	**Dependent Signature** *(not a minor)*	Today's Date

Applicant's Social Security Number

Q. Race/Ethnicity - Optional

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

R. Instructions: *Please refer to the current Aetna Advantage Plan brochure prior to completing this application.*

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.
- If you are paying by personal check or money order, please make your check or money order payable to Aetna.

You are ineligible for coverage if applicant is currently pregnant (whether or not listed on the application) or in the process of adoption; or any non-citizen applicant has 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.

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 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.**

T. Billing Information

- Make sure that your premium check is attached to the application.
- Complete Easy Pay (Section M) if you choose the Electronic Fund Transfer (EFT) option and attach a blank check marked "VOID".

U. Contact Information

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

Aetna Advantage Plans for Individuals & Families
Mail Stop F230
P. O. Box 61516
King of Prussia, PA 19406-0916

Fax #: 866-223-2041
www.aetna.com