Aetna Health Insurance Application – Illinois

Download / Print the application form, then complete it by hand.

Print using blue or black ink. No pencil or correction fluid please.

Some Important Application Considerations:

- Most errors occur in the completion of Section F (Health History) and of Section G (Health Related Questions). For any health conditions indicated in the completion of Section F, you must provide complete corresponding details in Section H (Detailed Health Information). If you need more space to provide these details, use an additional sheet of paper. If you use an additional sheet of paper, you need to sign and date it.
- Be sure all applicants of legal age sign/date the application in the appropriate areas – Section K on page 4 and Section M on page 5.
- At the top of each page is a field labeled "Enrollment Form ID Number." Ignore this, as it's for Aetna internal purposes only.
- Aetna bills on a monthly basis and a one-month premium deposit is required. You can arrange for Aetna to mail you a monthly bill or conveniently transfer monthly payments from a designated checking account (Electronic Fund Transfer – EFT). If you want EFT payment, you'll need to provide bank account information in Section O of the application. The Credit Card Payment Option (Section P) is for initial payment only.
- **A payment must accompany your application.** Provide a one-month payment – Payable to "Aetna." You can pay with a check or via credit card or via Electronic Fund Transfer (EFT). Applications cannot be processed without payment.
- If Aetna declines to insure you, or if you do not accept Aetna's health insurance offer, Aetna will provide a full refund of the payment submitted with your application.

Submit the application and payment (a check payable to Aetna, credit card payment or EFT) to:

MedPlan Access
6 Grapevine Place
P.O. Box 2220
West Lafayette IN 47906

...Or You can Fax Your Aetna Application
For faster processing of your Aetna application, fax the application documents to MedPlan Access at 765-464-3301. If you fax the application, you need charge your initial payment to a credit card, or authorize Aetna to fund monthly payments via Electronic Funds Transfer (EFT).

We will be pleased to review the plan and application with you. Just contact us.

Approval of applications generally takes two to six weeks following submission to Aetna. The key factors in this process are 1) the completeness of your submitted application, 2) whether Aetna requires copies of medical records and 3) how long it takes a physician or hospital to respond to an Aetna request (should a request be made) for medical records.

Joe Risse
MedPlan Access
1-877-MedPlan (1-877-633-7526)
joer@medplanaccess.com

Proceed to Application
▼

Aetna Advantage Plans for Individuals, Families and Self Employed

Subscriber's Social Security Number

Enrollment Form ID Number

Instructions:

- Enrollment form must be completed by the subscriber in blue or black ink. **(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 K and Page 5, Section M for all subscribers including spouse and children age 18 and over.
- PPO products are underwritten by Aetna Life Insurance Company through a blanket trust arrangement in Delaware.
- Any family member currently pregnant (whether or not listed on this enrollment form) or in the process of adoption or surrogacy does not qualify for this program.

Send completed enrollment form to:
MedPlan Access
P.O. Box 2200
West Lafayette IN 47906

A. Subscriber Information

Name

Maiden Name of Subscriber/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 ( )

Choose desired benefit plan type:
☐ IL PPO 500 ☐ IL PPO 1500 ☐ IL PPO 5000
☐ IL PPO 1000 ☐ IL PPO 2500
☐ PPO High Deductible 3000 (HSA Compatible)
☐ PPO High Deductible 5000 (HSA Compatible)
☐ Preventative and Hospital Care 1250
☐ Preventative and Hospital Care 3000 (HSA Compatible)
☐ Dental (Dental option only available with Medical)

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 ☐ Single ☐ Married

Occupation

E-mail Address

Reason for Enrollment Form
☐ New Enrollment
☐ Add Spouse/Dependent Child to an Existing Plan
☐ Add Dependent Child Only to an Existing Plan
☐ Change Existing Benefit Plan

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

Do you read and write English? ☐ Yes ☐ No

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 up to age 19; and between the ages of 19 through 22 with proof of full-time student status.)*

☐ ***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	Full-time Student Age 19 or Older	Height: (ft / in)		Weight: (lbs)
APP	Subscriber							Yes N/A			
SP	Spouse							N/A			
01	Dependent							☐			
02	Dependent							☐			
03	Dependent							☐			

C. Dependent Information

Do you claim all children listed above who are between the ages of 19 through 22 as dependents on your Federal Income Tax? ☐ Yes ☐ No

If "NO", any child between the ages of 19 through 22 who is not claimed on your Federal Income Tax is NOT eligible as a dependent but may apply for coverage independently.

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

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

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

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

Has any subscriber 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:
Subscriber Name: _____ Explanation: _____

Subscribers 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 below: _____

Are any subscribers listed above eligible for Medicare? ☐ Yes ☐ No
Subscriber Name: _____

E. 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 M) 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.

Aetna Use Only Y - N - U

Effective Date:

Number:

Subscriber's Social Security Number

Enrollment Form ID Number

F. Health History for Subscriber 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 H. | **Missing information may delay processing this enrollment form.**

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

F1.	**Eyes, Ears, Nose and Throat Conditions/Disorders:** *Eyes/sight:* glaucoma, cataracts, crossed eyes, detached retina, corneal transplant, infections; *Ears/Hearing:* loss of hearing, deafness, infections, eustachian tube dysfunction; *Nose/breathing:* deviated septum, polyps, adenoiditis, sinusitis; *Throat/Swallowing:* tonsillitis, strep throat, excessive snoring or sleep apnea, etc.?	☐ Yes ☐ No
F2.	**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.?	☐ 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, collapsed lung, emphysema, COPD, tuberculosis, fungal infections, difficulty breathing, spitting/coughing up blood, 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 gall bladder, hepatitis A/B/C/other, jaundice, Cirrhosis, unexplained weight loss or gain, eating disorder, Gastric Bypass/ Banding, etc.?	☐ Yes ☐ No
F6.	**Urinary Conditions/Disorders:** Bladder infections, kidney infections, stones, blood in urine, stress incontinence, urinary frequency, painful/ difficult urination, cystitis, bed wetting, etc.?	☐ Yes ☐ No
F7.	**Heart and Circulatory Conditions/Disorders:** Anemia, bleeding/clotting disorders, Hemophilia, 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.?	☐ Yes ☐ No
F8.	**Metabolic and Endocrine Conditions/Disorders:** Diabetes, adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis, thyroid disorders, AIDS/ARC, any immune disorder (not including the result for the HIV test)?	☐ Yes ☐ No
F9.	**Brain/Nervous System Conditions/Disorders:** Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, confusion, memory loss, Alzheimer's, dementia, head injury, stroke, migraine headaches or chronic severe headaches, narcolepsy, sleep apnea, tremors, Multiple Sclerosis, seizures/epilepsy, Muscular Dystrophy and Reflex Sympathetic Dystrophy (RSD), etc.?	☐ Yes ☐ No
F10.	**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.?	☐ Yes ☐ No
F11.	**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.?	☐ Yes ☐ 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: Subscriber Name _____ Reason _____	☐ Yes ☐ No
	c) Has any ***female*** had an abnormal PAP Smear? If Yes, provide details in **H1**. Date of last normal PAP Smear: Subscriber Name _____ Date _____	☐ Yes ☐ No
	d) Is any ***female*** subscriber pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate? If Yes, provide name: Subscriber 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, anorexia/bulimia, schizophrenia, etc.?	☐ Yes ☐ No
F13.	**Cancer/Tumors:** Cysts, tumors or abnormal growths, Hodgkin's disease, leukemia or any other cancer or malignancy?	☐ 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 subscriber consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s) not listed on this enrollment form?	☐ 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.

Subscriber's Social Security Number

Enrollment Form ID Number

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

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

G1.	Is any ***male*** subscriber 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 subscriber name below. Subscriber Name: _____	☐ Yes ☐ No
G2.	Has any subscriber been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? If Yes, provide subscriber name(s) below. Subscriber Name: _____ Subscriber Name: _____	☐ Yes ☐ No
G3.	Has any subscriber ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal or IV drugs? Subscriber Name: _____ Type of Drug/Substance: _____ Date Discontinued: _____ Subscriber Name: _____ Type of Drug/Substance: _____ Date Discontinued: _____	☐ Yes ☐ No
G4.	Has any subscriber 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.) Subscriber Name: _____ Type: _____ Amount: _____ per ☐ Day ☐ Week ☐ Month Subscriber Name: _____ Type: _____ Amount: _____ per ☐ Day ☐ Week ☐ Month	☐ Yes ☐ No
G5.	Has any subscriber been convicted of a DUI (drunk driving violation)? If Yes, provide subscriber name(s), state(s) and dates. Subscriber Name _____ State _____ Date _____ Subscriber Name _____ State _____ Date _____	☐ Yes ☐ No
G6.	Has any subscriber had any ***abnormal*** lab results, X-rays, MRI or other diagnostic test results or physical exam results?	☐ Yes ☐ No
G7.	Has any subscriber been medically advised to undergo further medical testing, treatment or surgery which has not yet been completed?	☐ Yes ☐ No
G8.	Has any subscriber been a patient in an outpatient clinic, hospital, surgical center, treatment center or other medical facility in the last 10 years?	☐ Yes ☐ No
G9.	Has any subscriber seen any health care provider for any condition, signs or symptoms which have not yet been diagnosed?	☐ Yes ☐ No
G10.	Has any subscriber smoked or used tobacco products, such as Snuff and/or chewing tobacco, in the last 2 years? If Yes, Provide Subscriber(s) below. Subscriber Name: _____ Date Stopped _____ Subscriber Name: _____ Date Stopped _____	☐ Yes ☐ No
G11.	Has any subscriber taken prescription medications or been advised to take prescription medications in the last 2 years?	☐ Yes ☐ No
G12.	Has any subscriber ever seen, received treatment from or consulted any health care provider for any other condition or symptom(s) not listed on this enrollment form?	☐ Yes ☐ No
G13.	Is any subscriber a candidate for, or a recipient of, an organ, bone marrow or stem cell transplant?	☐ Yes ☐ No
G14.	Is any subscriber currently on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	☐ Yes ☐ No

H. Detailed Health Information

☐ ***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.***

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

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

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

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

Subscriber's Social Security Number

Enrollment Form ID Number

H. 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(s)

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
				Normal	Abnormal: Give Details	
APP						
SP						
01						
02						
03						

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

I. 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 _____

J. 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 subscriber, 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.

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

Subscriber/Parent or Legal Guardian Signature	Today's Date
Subscriber/Spouse Signature	Today's Date
Subscriber's Dependent *(Not a minor)*	Today's Date

Subscriber's Social Security Number
| | | | | | | | |

Enrollment Form ID Number
| | | | | | | | |

L. 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. 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. I authorize Aetna to request my and/or my dependents' (those who are applying 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 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 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 subscribers; 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 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.
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 Enrollment form after the signature of this Enrollment form 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 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.
6. Information on agent's compensation is available from your agent or at Aetna.com.
7. Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form for insurance or statement of claim containing any material false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

M. Signature(s) Required - **All subscribers age 18 and over must sign and date below.**
If subscriber 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 any misrepresentation and/or mistake in such information 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.

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

Subscriber's Social Security Number

Enrollment Form ID Number

N. Important Subscriber Information **Please Read Carefully**

1. Coverage may be declined, or a premium adjustment made, based on information provided to Aetna during the enrollment process. In the case of denial, 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 denied coverage, the original check will be returned directly to the subscriber.
2. 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

O. Easy Pay (Electronic Fund Transfer - EFT)

☐ **Yes**, I would like to use Easy Pay.

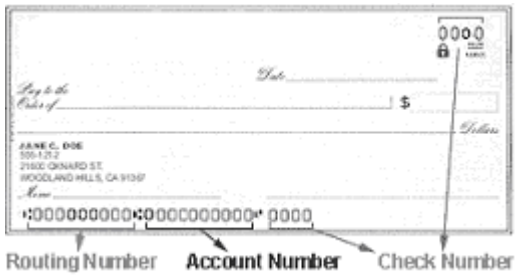
Checking Account Number: _____

Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Bank: _____

Name(s) on Checking Account: _____

☐ **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. No bill will be issued**. I understand that by checking the "Yes" box above and with my enrollment form signature on Page 5 (Section M) 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. Please be advised that such rate adjustment may result in an increase of 25% to 50% of the standard rate.

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 M) even if not applying.

P. Credit Card Payment Option

Credit Card Type

☐ VISA ☐ MasterCard

Cardholder's Name (exactly as it appears on the card)

Account Number	Card Expiration Date	Card Verification Code*
☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐		☐☐☐

Credit card payment is for your initial premium payment only. You will receive a bill on your next billing statement.

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 25% to 50% of the standard rate.

*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. Payment by Personal Check or Money Order

Please include a personal check or money order made payable to “Aetna” and attach to your completed enrollment form.

R. Statement of Accountability - To be completed if the subscriber cannot or has not completed the enrollment form.

I, _____ , personally read and completed the Individual Enrollment form for the subscriber named below because: ☐ Subscriber does not read English ☐ Subscriber does not speak English ☐ Subscriber 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 Subscriber _____

Subscriber's Social Security Number
| | | | | | | | |

Enrollment Form ID Number
| | | | | | | |

S. Insurance Producer Information (If applicable)

	General Agent	Insurance Broker
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.	☐ Yes ☐ No N/A	☐ Yes ☐ No
2. Did you see the proposed applicant at the time this application was executed? If No, please explain:	☐ Yes ☐ No N/A	☐ Yes ☐ No

Signature of Insurance Producer *(Required)*		**Signature of General Agent** *(Required, if applicable)*	
Date	E-mail Address joer@medplanaccess.com	Date	E-mail Address
Name of Insurance Producer or Agency to be assigned as Broker of Record (print name) Joe Risse / MedPlan Access		Name of General Agent (print name) N/A	
TIN of Producer or Agency to be assigned as Broker of Record 35-1938836		Agent TIN Number	
Street Address (Street, Suite No./Personal Mail Box (PMB) No., City/State/ZIP Code) P.O. Box 2220 West Lafayette IN 47906		Street Address (Street, Suite No./Personal Mail Box (PMB) No., City/State/ZIP Code)	
Telephone Number (877) 633-7526	FAX Number (765) 464-3301	Telephone Number ( )	FAX Number ( )

T. Aetna Sales Representative

Last Name of Sales Representative (print name)	First Name of Sales Representative (print name)
N/A	N/A

U. Instructions: *Please refer to the current Aetna Advantage Plan brochure prior to completing this enrollment form.*

Please review these instructions.

- The Subscriber 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 Subscriber is currently pregnant (whether or not listed on the enrollment form) or in the process of adoption; or any non-citizen Subscriber has 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.

V. 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 Subscriber chooses a PPO product, complete the Joinder agreement section.

W. Payment Options

Carefully read the instructions accompanying each payment option (Page 6, Sections O, P and Q).

X. Contact Information

Please return this enrollment form to the agent:

MedPlan Access
P.O. Box 2220
West Lafayette IN 47906 **Fax #: 765-464-3301**