HIPAA* Coverage Form – Florida

*(Health Insurance Portability and Accountability Act)

Please mail this form to:
Aetna
Attn: Unit 212
PO Box 730
Blue Bell, PA 19422

Demographic Information

Last Name, First Name, M.I.				
Home Address (P.O. Box not acceptable)				
City			State	Zip
Billing Address (If different than above address)				
City		State	Zip	**County *(Required)***
Gender ☐ Male ☐ Female	Date of Birth	Social Security Number		Home Telephone Number

Dependent Information

1. Last Name, First Name, M.I.			
Relationship ☐ Spouse ☐ Child	Gender ☐ Male ☐ Female	Date of Birth	Social Security Number
2. Last Name, First Name, M.I.			
Relationship ☐ Spouse ☐ Child	Gender ☐ Male ☐ Female	Date of Birth	Social Security Number
3. Last Name, First Name, M.I.			
Relationship ☐ Spouse ☐ Child	Gender ☐ Male ☐ Female	Date of Birth	Social Security Number

HIPAA Eligibility

1. Have you had a minimum of 18 months of continuous health coverage most recently under an Employers-sponsored group health plan that ended within the last 63 days for a reason other than fraud or non-payment of premium? ..... ☐ Yes ☐ No
   If **Yes,** please attach the Certificate of Coverage provided by your former employer or carrier OR letter from your employer giving us the start and end date of coverage.
   Name of insurance carriers: _____ Telephone Number (____)_____
   If **No,** you are **not** eligible for this guarantee issue plan.
2. Were you eligible for COBRA? ..... ☐ Yes ☐ No
   If **Yes,** Date coverage started (Mo/Day/Year): _____
   Date coverage ended (Mo/Day/Year): _____
   If **No**, please explain: _____
3. Are you currently covered by or eligible for Medicaid, Medicare or any other employer-sponsored Health insurance benefits or do you have other health coverage? ..... ☐ Yes ☐ No
   If **Yes,** you are **not** eligible for this coverage.
4. Were you cancelled for fraud or non-payment of premium? ..... ☐ Yes ☐ No
   If Yes, you are not eligible for this coverage.
5. If you applied for the Aetna Advantage Plans for Individuals and Families, the following requirements must be met:
   a. You must have applied for the Aetna Advantage Plans for Individuals and Families within 63 days of the end date of your previous plan.
   b. You must have inquired about the HIPAA plan within 30 days of the declination for enrollment in the Aetna Advantage Plans for Individuals and Families OR within 63 days of the previous plan.

Effective Date

Aetna may assign an effective date of the 1st or the 15th of the month following the approval date. Effective date must be within 63 days of the prior coverage termination date. Aetna may allow a retroactive effective date of the 1st or 15th of the month following the prior coverage termination date.

Conditions and Agreement
It is important that you read and understand the following before you sign.

Agreement

I, the undersigned, agree to the following:

1. No coverage will come into effect until Aetna notifies me in writing.
2. Coverage and benefits once they come to 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 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.
4. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Authorization

I authorize any physician, other healthcare professional, hospital, pharmacy, pharmacy benefit manager or any other healthcare organizations ("Providers") to give Aetna or its agents information concerning the medical history, prescription history, services or treatment provided to the applicant listed on this HIPAA coverage form, including those involving mental health, substance abuse and AIDS/ARC. I further authorize Aetna to use such information and disclose 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 understand that this authorization is provided under state law, and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act ("HIPAA"). 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 HIPAA coverage form prior to the effective date in considering my application. 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.

Signature Required

I represent that all information supplied in this form is true and correctly recorded by me. I have myself read, understand and agree to the Conditions and Agreement. I understand that any misrepresentation and/or mistake in such information supplied, will be reason for cancellation/termination of coverage.

I UNDERSTAND THAT IF MY SIGNATURE/DATE DO NOT APPEAR AND/OR ARE NOT CURRENT AND/OR MY ANSWERS ARE INCOMPLETE, COVERAGE MAY BE AFFECTED.

Signature	Date

Aetna Sales Agent

Last Name of Sales Representative (print name)	First Name of Sales Representative (print name)
Agent's Signature	Date

PAYMENT OPTIONS

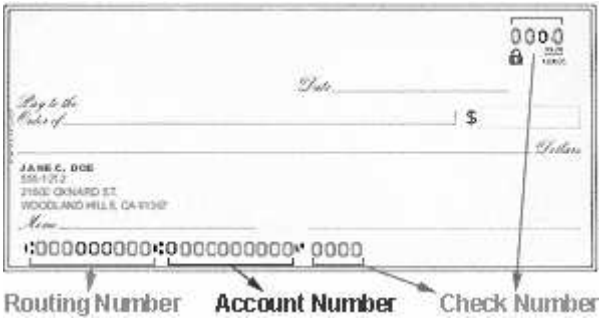
Easy Pay (Electronic Funds Transfer –EFT)

☐ Yes, I would like to use Easy Pay.

Checking Account Number: _____ Routing Number | | | | | | | | | |

Name of Bank: _____

Names on Checking Account: _____



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

Terms of Agreement: My account(s) at the institution named has sufficient funds to pays all debts 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 my signature on page 2 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.

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.**

* 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.

Payment by Personal Check or Money Order

Please include a personal check or money order made payable to "Aetna" and attach to this form.

Statement of Accountability – to be completed if the individual to be covered cannot or has not completed this HIPAA Coverage Form.

I, _____, personally read and completed the HIPAA Coverage Form for the individual named below because:

☐ Individual does not read English ☐ Individual does not speak English ☐ Individual 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 information disclosed by: _____

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

Signature of Translator ***(Required)***: _____ Today's Date ***(Required)***: _____

Relationship to Individual _____