



Aetna Advantage Plans  
PO Box 14381  
Lexington, KY 40512-4381

**Q R-POD**

Applicant's Social Security Number									

Application ID Number									

**B. Individuals Covered (Dependent children are covered up to age 26.)**

☐ 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 application.

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/Domestic Partner						
01	Dependent						
02	Dependent						

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

Do you currently have any health care coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are your spouse/domestic partner/children covered also?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Provide name of current (or most recent) health care carrier and coverage termination date (if applicable).			
Name: _____		Term Date: _____	
Are any family members listed above currently enrolled in an Aetna Plan?			
<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide the following information.			
Name(s): _____		Relationship: _____	ID No.: _____
Has any person listed on this application ever been declined, postponed, had a waiver applied or charged an additional premium for life, disability or health insurance?			
<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide the following information.			
Name: _____			
Explanation: _____			
Has any person listed on this application had their health insurance rescinded?			
<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide the following information.			
Name: _____			
Date: _____			
Explanation: _____			
Has any person listed on this application ever filed a claim and/or received benefits from disability insurance or Workers' Compensation?			
<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide the following information.			
Name: _____			
Date: _____			
Explanation: _____			
Are any persons listed above eligible for Medicare?			
<input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____			
_____			

**Health History**

<p><b>Each applicant must complete a separate Health History section.</b></p> <p>You must provide truthful and complete answers to the following questions to the best of your ability. Aetna relies on the information provided to determine if you are eligible for coverage. We have the right to review medical records, pharmacy and claims history to verify the accuracy of your information. Even if you have had prior or have current coverage with Aetna, you must fully answer all the questions.</p> <p>All questions must be answered or your application will be returned. If you cannot answer a question, provide details or are not sure of a medical term please check "Not Sure". Aetna will contact you and/or your health care providers to assist with your medical history.</p>
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**Applicant Name**

**D. Health History for Primary Applicant**

**If you answer "Yes" or "Not Sure" on any of the questions below, provide details on Pages 5 and 6.**

**In the past five (5) years, have you the primary applicant consulted a health care provider, received treatment (including prescription medications) or been hospitalized for any of the following conditions or diseases?**

D1.	<b>Eyes, Ears, Nose and Throat Conditions/Disorders:</b> <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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D2.	<b>Skin Conditions/Disorders:</b> Acne, psoriasis, keratosis Birthmarks, dermatitis, eczema, fungal infections, warts, herpes, excessive sweating Moles/pre-cancerous lesions, skin cancer, or melanoma 2nd or 3rd degree burns, scars/keloid, or revisions of cosmetic or reconstructive surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D3.	<b>Musculoskeletal Conditions/Disorders:</b> Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as: Strain/sprain, fibromyalgia, gout Fracture, internal/external fixations, permanent hardware, amputation/prosthesis Arthritis, joint replacement, herniated disc, back or neck pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D4.	<b>Respiratory Conditions/Disorders:</b> Allergies, sinusitis, bronchitis, asthma, pneumonia, collapsed lung, spitting/coughing up blood Shortness of breath, chronic cough, emphysema, COPD, difficulty breathing Tuberculosis, fungal infections	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D5.	<b>Digestive Conditions/Disorders:</b> Infections of mouth/throat/tonsils Problems with jaw or chewing, ulcers, hernia, gastric reflux, unexplained weight loss or gain, eating disorder, Gastric Bypass/Banding 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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D6.	<b>Urinary Conditions/Disorders:</b> Bladder infections, kidney infections, stones, blood in urine Stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D7.	<b>Heart and Circulatory Conditions/Disorders:</b> Anemia, bleeding/clotting disorders, Hemophilia, thrombocytopenia, Varicose/spider veins, Raynauds, phlebitis, thrombosis, enlarged lymph nodes or lymphadenitis High blood pressure (hypertension), low blood pressure, high cholesterol/lipids Chest pain, angina, heart murmur, palpitations, congestive heart failure, coronary artery disease, rheumatic fever Heart attack, bypass surgery/angioplasty, valve replacement, prolapsed or leaky valve, pacemaker or defibrillator, aneurysm	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D8.	<b>Metabolic and Endocrine Conditions/Disorders:</b> Diabetes, Insulin Resistance, Metabolic Syndrome, Thyroid disorders Adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis Or other immune disorder (not including the result for the HIV test)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D9.	<b>Brain/Nervous System Conditions/Disorders:</b> Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, narcolepsy, sleep apnea Confusion, memory loss, Alzheimer's, dementia, head injury, seizures/epilepsy Stroke, paralysis, migraine headaches or chronic severe headaches Tremors, Multiple Sclerosis, Muscular Dystrophy, Reflex Sympathetic Dystrophy (RSD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

*continued*

Applicant's Social Security Number									

Application ID Number									

#### D. Health History for Primary Applicant (Continued)

D10.	<b>Male Reproductive Conditions/Disorders:</b> a) Fertility/infertility, low sperm count, sexual dysfunction Erectile dysfunction, enlarged prostate, prostatitis, undescended testes Genital or anal herpes/warts, sexually transmitted diseases b) Are you 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D11.	<b>Female Reproductive Conditions/Disorders:</b> a) Pelvic pain, abnormal menstrual bleeding, endometriosis, ovarian cysts, absence of menstruation Abnormal PAP smear, uterine fibroids, fertility/infertility, miscarriage, genital warts/herpes or sexually transmitted diseases Breast cysts/lumps/fibroids, breast implants b) Has it been more than 40 days since you had your last menstrual period? If "Yes," check one: <input type="checkbox"/> Menopause <input type="checkbox"/> Birth Control <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Other (provide reason): _____ c) Have you had an abnormal PAP smear? If "Yes," provide details on <b>Page 5</b> . Date of last normal PAP smear. Date: _____ d) Are you currently pregnant, tested positive with a home pregnancy test, or in the process of adoption or using a surrogate?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D12.	<b>Nervous, Mental and Behavioral:</b> Depression, anxiety, obsessive-compulsive or panic disorders, eating disorders, anorexia/bulimia Attention deficit, chemical imbalance, bi-polar, schizophrenia Substance abuse, counseling or support group, alcohol or chemical dependence	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D13.	<b>Cancer/Tumors:</b> Cysts, tumors or abnormal growths Hodgkin's disease, leukemia or any other cancer or malignancy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D14.	<b>Birth Defects/Congenital Abnormalities:</b> Cerebral Palsy, Birthmarks, developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation Cleft palate/lip, club foot, webbed fingers/toes, skull/facial or other physical deformities	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D15.	In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D16.	In the past 5 years, have you ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: _____ Date Discontinued: _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D17.	Have you consumed any alcoholic beverage in the past 6 months? (Amount: A drink is 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor.) Type: _____ Amount: _____ _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D18.	In the past 5 years, have you been convicted of a DUI (drunk driving violation)? If "Yes," provide state(s) and date(s). Name: _____ State: _____ Date: _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D19.	In the past 5 years, have you been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), or ARC (Aids Related Complex)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D20.	In the past five (5) years, have you received any lab results, X-rays, MRI or other diagnostic test results or physical exam results from a physician or medical practitioner that were considered <b>abnormal</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D21.	In the past 5 years, have you 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 <input type="checkbox"/> Not Sure

continued

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#### D. Health History for Primary Applicant (Continued)

D22.	In the past 5 years, have you been a patient in an outpatient clinic, surgical center, urgent care, treatment center or inpatient in a hospital or other medical facility for any reason other than pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D23.	Are you a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D24.	Are you 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 <input type="checkbox"/> Not Sure
D25.	Have you smoked or used tobacco products, such as snuff and/or chewing tobacco, in the past 12 months? Date Stopped: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D26.	Have you taken prescription medications or been advised to take prescription medications in the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D27.	Within the past two (2) years, have you seen a health care provider (physician, physicians assistant, nurse practitioner, chiropractor, physical therapist or any licensed provider) <b>not already disclosed on this application</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
D28.	Within the past two (2), years have you had any change in your health status, an illness, or injury not mentioned on your application <b>that you have NOT seen a health care provider for</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

**NOTICE:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

**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.

#### Medical History and Treatment History for the Primary Applicant

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

**If you have answered "Yes" to any of the questions in Section D, you must provide detailed information below.**

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

Date of Onset/Treatment (mm/yyyy): \_\_\_\_\_ Date ended: \_\_\_\_\_ ☐ Still under treatment

Treatment(X-ray, Labs, surgical procedure, therapy): \_\_\_\_\_

Name of Hospital, clinic or Health Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

Date of Onset/Treatment (mm/yyyy): \_\_\_\_\_ Date ended: \_\_\_\_\_ ☐ Still under treatment

Treatment(X-ray, Labs, surgical procedure, therapy): \_\_\_\_\_

Name of Hospital, clinic or Health Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

Date of Onset/Treatment (mm/yyyy): \_\_\_\_\_ Date ended: \_\_\_\_\_ ☐ Still under treatment

Treatment(X-ray, Labs, surgical procedure, therapy): \_\_\_\_\_

Name of Hospital, clinic or Health Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

*continued*

Applicant's Social Security Number									

Application ID Number									

**D. Health History for Primary Applicant (Continued)**

**Medical History and Treatment History for the Primary Applicant**

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

**If you have answered "Not Sure" to any of the questions in Section D, you must provide detailed information below.**

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

☐ Do not understand the medical terms used

☐ Do not understand the question

☐ Do not know if you have the listed condition

☐ Had or have the listed condition but cannot remember details

**Provide any additional information to explain why you answered "Not Sure"**

\_\_\_\_\_

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

☐ Do not understand the medical terms used

☐ Do not understand the question

☐ Do not know if you have the listed condition

☐ Had or have the listed condition but cannot remember details

**Provide any additional information to explain why you answered "Not Sure"**

\_\_\_\_\_

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

☐ Do not understand the medical terms used

☐ Do not understand the question

☐ Do not know if you have the listed condition

☐ Had or have the listed condition but cannot remember details

**Provide any additional information to explain why you answered "Not Sure"**

\_\_\_\_\_

**Medication or Pharmacy History for the Primary Applicant**

List all medications prescribed and/or taken in the past twelve (12) months

Medication Name (i.e. Ativan)	Frequency and route (i.e. daily/oral)	Condition for which medication was prescribed	Date Prescribed (mm/yyyy)	Date Stopped (mm/yyyy)	Still Taking
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

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Spouse/Domestic Partner Name									
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### E. Health History for Spouse/Domestic Partner

If you answer "Yes" or "Not Sure" on any of the questions below, provide details on Pages 9 and 10.

In the past five (5) years, have you, (Spouse/Domestic Partner) consulted a health care provider, received treatment (including prescription medications) or been hospitalized for any of the following conditions or diseases?

E1.	<b>Eyes, Ears, Nose and Throat Conditions/Disorders:</b> <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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E2.	<b>Skin Conditions/Disorders:</b> Acne, psoriasis, keratosis Birthmarks, dermatitis, eczema, fungal infections, warts, herpes, excessive sweating Moles/pre-cancerous lesions, skin cancer, or melanoma 2nd or 3rd degree burns, scars/keloid, or revisions of cosmetic or reconstructive surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E3.	<b>Musculoskeletal Conditions/Disorders:</b> Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as: Strain/sprain, fibromyalgia, gout Fracture, internal/external fixations, permanent hardware, amputation/prosthesis Arthritis, joint replacement, herniated disc, back or neck pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E4.	<b>Respiratory Conditions/Disorders:</b> Allergies, sinusitis, bronchitis, asthma, pneumonia, collapsed lung, spitting/coughing up blood Shortness of breath, chronic cough, emphysema, COPD, difficulty breathing Tuberculosis, fungal infections	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E5.	<b>Digestive Conditions/Disorders:</b> Infections of mouth/throat/tonsils Problems with jaw or chewing, ulcers, hernia, gastric reflux, unexplained weight loss or gain, eating disorder, Gastric Bypass/Banding 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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E6.	<b>Urinary Conditions/Disorders:</b> Bladder infections, kidney infections, stones, blood in urine Stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E7.	<b>Heart and Circulatory Conditions/Disorders:</b> Anemia, bleeding/clotting disorders, Hemophilia, thrombocytopenia, Varicose/spider veins, Raynauds, phlebitis, thrombosis, enlarged lymph nodes or lymphadenitis High blood pressure (hypertension), low blood pressure, high cholesterol/lipids Chest pain, angina, heart murmur, palpitations, congestive heart failure, coronary artery disease, rheumatic fever Heart attack, bypass surgery/angioplasty, valve replacement, prolapsed or leaky valve, pacemaker or defibrillator, aneurysm	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E8.	<b>Metabolic and Endocrine Conditions/Disorders:</b> Diabetes, Insulin Resistance, Metabolic Syndrome, Thyroid disorders Adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis Or other immune disorder (not including the result for the HIV test)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E9.	<b>Brain/Nervous System Conditions/Disorders:</b> Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, narcolepsy, sleep apnea Confusion, memory loss, Alzheimer's, dementia, head injury, seizures/epilepsy Stroke, paralysis, migraine headaches or chronic severe headaches Tremors, Multiple Sclerosis, Muscular Dystrophy, Reflex Sympathetic Dystrophy (RSD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

continued

Applicant's Social Security Number									

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### E. Health History Health History for Spouse/Domestic Partner (Continued)

E10.	<b>Male Reproductive Conditions/Disorders:</b> a) Fertility/infertility, low sperm count, sexual dysfunction Erectile dysfunction, enlarged prostate, prostatitis, undescended testes Genital or anal herpes/warts, sexually transmitted diseases b) Are you 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E11.	<b>Female Reproductive Conditions/Disorders:</b> a) Pelvic pain, abnormal menstrual bleeding, endometriosis, ovarian cysts, absence of menstruation Abnormal PAP smear, uterine fibroids, fertility/infertility, miscarriage, genital warts/herpes or sexually transmitted diseases Breast cysts/lumps/fibroids, breast implants b) Has it been more than 40 days since you had your last menstrual period? If "Yes," check one: <input type="checkbox"/> Menopause <input type="checkbox"/> Birth Control <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Other (provide reason): _____ c) Have you had an abnormal PAP smear? If "Yes," provide details on <b>Page 9</b> . Date of last normal PAP smear. Date: _____ d) Are you currently pregnant, tested positive with a home pregnancy test, or in the process of adoption or using a surrogate?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E12.	<b>Nervous, Mental and Behavioral:</b> Depression, anxiety, obsessive-compulsive or panic disorders, eating disorders, anorexia/bulimia Attention deficit, chemical imbalance, bi-polar, schizophrenia Substance abuse, counseling or support group, alcohol or chemical dependence	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E13.	<b>Cancer/Tumors:</b> Cysts, tumors or abnormal growths Hodgkin's disease, leukemia or any other cancer or malignancy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E14.	<b>Birth Defects/Congenital Abnormalities:</b> Cerebral Palsy, Birthmarks, developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation Cleft palate/lip, club foot, webbed fingers/toes, skull/facial or other physical deformities	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E15.	In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E16.	In the past 5 years, have you ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: _____ Date Discontinued: _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E17.	Have you consumed any alcoholic beverage in the past 6 months? (Amount: A drink is 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor.) Type: _____ Amount: _____ _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E18.	In the past 5 years, have you been convicted of a DUI (drunk driving violation)? If "Yes," provide state(s) and date(s). Name: _____ State: _____ Date: _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E19.	In the past 5 years, have you been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), or ARC (Aids Related Complex)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E20.	In the past five (5) years, have you received any lab results, X-rays, MRI or other diagnostic test results or physical exam results from a physician or medical practitioner that were considered <b>abnormal</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E21.	In the past 5 years, have you 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 <input type="checkbox"/> Not Sure

continued



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### E. Health History Health History for Spouse/Domestic Partner (Continued)

E22.	In the past 5 years, have you been a patient in an outpatient clinic, surgical center, urgent care, treatment center or inpatient in a hospital or other medical facility for any reason other than pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E23.	Are you a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E24.	Are you 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 <input type="checkbox"/> Not Sure
E25.	Have you smoked or used tobacco products, such as snuff and/or chewing tobacco, in the past 12 months? Date Stopped: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E26.	Have you taken prescription medications or been advised to take prescription medications in the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E27.	Within the past two (2) years, have you seen a health care provider (physician, physicians assistant, nurse practitioner, chiropractor, physical therapist or any licensed provider) <b>not already disclosed on this application</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
E28.	Within the past two (2), years have you had any change in your health status, an illness, or injury not mentioned on your application <b>that you have NOT seen a health care provider for</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

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### Medical History and Treatment History for Spouse/Domestic Partner

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

**If you have answered "Yes" to any of the questions in Section E, you must provide detailed information below.**

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

Date of Onset/Treatment (mm/yyyy): \_\_\_\_\_ Date ended: \_\_\_\_\_ ☐ Still under treatment

Treatment(X-ray, Labs, surgical procedure, therapy): \_\_\_\_\_

Name of Hospital, clinic or Health Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

Date of Onset/Treatment (mm/yyyy): \_\_\_\_\_ Date ended: \_\_\_\_\_ ☐ Still under treatment

Treatment(X-ray, Labs, surgical procedure, therapy): \_\_\_\_\_

Name of Hospital, clinic or Health Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

Date of Onset/Treatment (mm/yyyy): \_\_\_\_\_ Date ended: \_\_\_\_\_ ☐ Still under treatment

Treatment(X-ray, Labs, surgical procedure, therapy): \_\_\_\_\_

Name of Hospital, clinic or Health Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

*continued*

Applicant's Social Security Number									

Application ID Number									

**E. Health History for Spouse/Domestic Partner (Continued)**

**Medical History and Treatment History for the Spouse/Domestic Partner**

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

**If you have answered "Not Sure" to any of the questions in Section E, you must provide detailed information below.**

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

☐ Do not understand the medical terms used

☐ Do not understand the question

☐ Do not know if you have the listed condition

☐ Had or have the listed condition but cannot remember details

**Provide any additional information to explain why you answered "Not Sure"**

\_\_\_\_\_

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

☐ Do not understand the medical terms used

☐ Do not understand the question

☐ Do not know if you have the listed condition

☐ Had or have the listed condition but cannot remember details

**Provide any additional information to explain why you answered "Not Sure"**

\_\_\_\_\_

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

☐ Do not understand the medical terms used

☐ Do not understand the question

☐ Do not know if you have the listed condition

☐ Had or have the listed condition but cannot remember details

**Provide any additional information to explain why you answered "Not Sure"**

\_\_\_\_\_

**Medication or Pharmacy History for the Spouse/Domestic Partner**

List all medications prescribed and/or taken in the past twelve (12) months

Medication Name (i.e. Ativan)	Frequency and route (i.e. daily/oral)	Condition for which medication was prescribed	Date Prescribed (mm/yyyy)	Date Stopped (mm/yyyy)	Still Taking
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

Applicant's Social Security Number									

Application ID Number									

Dependent 01 Name

## F. Health History for Dependent 01

If you answer "Yes" or "Not Sure" on any of the questions below, provide details on Pages 13 and 14.

In the past five (5) years, have you, (Dependent 01) consulted a health care provider, received treatment (including prescription medications) or been hospitalized for any of the following conditions or diseases?

F1.	<b>Eyes, Ears, Nose and Throat Conditions/Disorders:</b> <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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F2.	<b>Skin Conditions/Disorders:</b> Acne, psoriasis, keratosis Birthmarks, dermatitis, eczema, fungal infections, warts, herpes, excessive sweating Moles/pre-cancerous lesions, skin cancer, or melanoma 2nd or 3rd degree burns, scars/keloid, or revisions of cosmetic or reconstructive surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F3.	<b>Musculoskeletal Conditions/Disorders:</b> Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as: Strain/sprain, fibromyalgia, gout Fracture, internal/external fixations, permanent hardware, amputation/prosthesis Arthritis, joint replacement, herniated disc, back or neck pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F4.	<b>Respiratory Conditions/Disorders:</b> Allergies, sinusitis, bronchitis, asthma, pneumonia, collapsed lung, spitting/coughing up blood Shortness of breath, chronic cough, emphysema, COPD, difficulty breathing Tuberculosis, fungal infections	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F5.	<b>Digestive Conditions/Disorders:</b> Infections of mouth/throat/tonsils Problems with jaw or chewing, ulcers, hernia, gastric reflux, unexplained weight loss or gain, eating disorder, Gastric Bypass/Banding 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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F6.	<b>Urinary Conditions/Disorders:</b> Bladder infections, kidney infections, stones, blood in urine Stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F7.	<b>Heart and Circulatory Conditions/Disorders:</b> Anemia, bleeding/clotting disorders, Hemophilia, thrombocytopenia, Varicose/spider veins, Raynauds, phlebitis, thrombosis, enlarged lymph nodes or lymphadenitis High blood pressure (hypertension), low blood pressure, high cholesterol/lipids Chest pain, angina, heart murmur, palpitations, congestive heart failure, coronary artery disease, rheumatic fever Heart attack, bypass surgery/angioplasty, valve replacement, prolapsed or leaky valve, pacemaker or defibrillator, aneurysm	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F8.	<b>Metabolic and Endocrine Conditions/Disorders:</b> Diabetes, Insulin Resistance, Metabolic Syndrome, Thyroid disorders Adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis Or other immune disorder (not including the result for the HIV test)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F9.	<b>Brain/Nervous System Conditions/Disorders:</b> Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, narcolepsy, sleep apnea Confusion, memory loss, Alzheimer's, dementia, head injury, seizures/epilepsy Stroke, paralysis, migraine headaches or chronic severe headaches Tremors, Multiple Sclerosis, Muscular Dystrophy, Reflex Sympathetic Dystrophy (RSD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

continued

Applicant's Social Security Number									

Application ID Number									

# **F. Health History Health History for Dependent 01 (Continued)**

F10.	<b>Male Reproductive Conditions/Disorders:</b> a) Fertility/infertility, low sperm count, sexual dysfunction Erectile dysfunction, enlarged prostate, prostatitis, undescended testes Genital or anal herpes/warts, sexually transmitted diseases b) Are you 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F11.	<b>Female Reproductive Conditions/Disorders:</b> a) Pelvic pain, abnormal menstrual bleeding, endometriosis, ovarian cysts, absence of menstruation Abnormal PAP smear, uterine fibroids, fertility/infertility, miscarriage, genital warts/herpes or sexually transmitted diseases Breast cysts/lumps/fibroids, breast implants b) Has it been more than 40 days since you had your last menstrual period? If "Yes," check one: <input type="checkbox"/> Menopause <input type="checkbox"/> Birth Control <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Other (provide reason): _____ c) Have you had an abnormal PAP smear? If "Yes," provide details on <b>Page 13</b> . Date of last normal PAP smear. Date: _____ d) Are you currently pregnant, tested positive with a home pregnancy test, or in the process of adoption or using a surrogate?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F12.	<b>Nervous, Mental and Behavioral:</b> Depression, anxiety, obsessive-compulsive or panic disorders, eating disorders, anorexia/bulimia Attention deficit, chemical imbalance, bi-polar, schizophrenia Substance abuse, counseling or support group, alcohol or chemical dependence	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F13.	<b>Cancer/Tumors:</b> Cysts, tumors or abnormal growths Hodgkin's disease, leukemia or any other cancer or malignancy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F14.	<b>Birth Defects/Congenital Abnormalities:</b> Cerebral Palsy, Birthmarks, developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation Cleft palate/lip, club foot, webbed fingers/toes, skull/facial or other physical deformities	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F15.	In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F16.	In the past 5 years, have you ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: _____ Date Discontinued: _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F17.	Have you consumed any alcoholic beverage in the past 6 months? (Amount: A drink is 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor.) Type: _____ Amount: _____ _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F18.	In the past 5 years, have you been convicted of a DUI (drunk driving violation)? If "Yes," provide state(s) and date(s). Name: _____ State: _____ Date: _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F19.	In the past 5 years, have you been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), or ARC (Aids Related Complex)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F20.	In the past five (5) years, have you received any lab results, X-rays, MRI or other diagnostic test results or physical exam results from a physician or medical practitioner that were considered <b>abnormal</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F21.	In the past 5 years, have you 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 <input type="checkbox"/> Not Sure

*continued*

Applicant's Social Security Number									

Application ID Number									

### F. Health History Health History for Dependent 01 (Continued)

F22.	In the past 5 years, have you been a patient in an outpatient clinic, surgical center, urgent care, treatment center or inpatient in a hospital or other medical facility for any reason other than pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F23.	Are you a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F24.	Are you 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 <input type="checkbox"/> Not Sure
F25.	Have you or used tobacco products, such as snuff and/or chewing tobacco, in the past 12 months? Date Stopped: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F26.	Have you taken prescription medications or been advised to take prescription medications in the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F27.	Within the past two (2) years, have you seen a health care provider (physician, physicians assistant, nurse practitioner, chiropractor, physical therapist or any licensed provider) <b>not already disclosed on this application</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
F28.	Within the past two (2), years have you had any change in your health status, an illness, or injury not mentioned on your application <b>that you have NOT seen a health care provider for</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

**NOTICE:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

**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.

### Medical History and Treatment History for Dependent 01

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

<b>If you have answered "Yes" to any of the questions in Section F, you must provide detailed information below.</b>	
Question Number: _____	
Name of Condition/Illness: _____	
Date of Onset/Treatment (mm/yyyy): _____	Date ended: _____ <input type="checkbox"/> Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): _____	
Name of Hospital, clinic or Health Care Provider: _____	
Address: _____	
City: _____	State: _____ ZIP: _____
Telephone Number: (____) _____	
Question Number: _____	
Name of Condition/Illness: _____	
Date of Onset/Treatment (mm/yyyy): _____	Date ended: _____ <input type="checkbox"/> Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): _____	
Name of Hospital, clinic or Health Care Provider: _____	
Address: _____	
City: _____	State: _____ ZIP: _____
Telephone Number: (____) _____	
Question Number: _____	
Name of Condition/Illness: _____	
Date of Onset/Treatment (mm/yyyy): _____	Date ended: _____ <input type="checkbox"/> Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): _____	
Name of Hospital, clinic or Health Care Provider: _____	
Address: _____	
City: _____	State: _____ ZIP: _____
Telephone Number: (____) _____	

continued

Applicant's Social Security Number									

Application ID Number									

**F. Health History for Dependent 01 (Continued)**

**Medical History and Treatment History for Dependent 01**

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

**If you have answered "Not Sure" to any of the questions in Section F, you must provide detailed information below.**

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

☐ Do not understand the medical terms used

☐ Do not understand the question

☐ Do not know if you have the listed condition

☐ Had or have the listed condition but cannot remember details

**Provide any additional information to explain why you answered "Not Sure"**

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

☐ Do not understand the medical terms used

☐ Do not understand the question

☐ Do not know if you have the listed condition

☐ Had or have the listed condition but cannot remember details

**Provide any additional information to explain why you answered "Not Sure"**

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

☐ Do not understand the medical terms used

☐ Do not understand the question

☐ Do not know if you have the listed condition

☐ Had or have the listed condition but cannot remember details

**Provide any additional information to explain why you answered "Not Sure"**

**Medication or Pharmacy History for Dependent 01**

List all medications prescribed and/or taken in the past twelve (12) months

Medication Name (i.e. Ativan)	Frequency and route (i.e. daily/oral)	Condition for which medication was prescribed	Date Prescribed (mm/yyyy)	Date Stopped (mm/yyyy)	Still Taking
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

Applicant's Social Security Number									

Application ID Number									

Dependent 02 Name

### G. Health History for Dependent 02

If you answer "Yes" or "Not Sure" on any of the questions below, provide details on Pages 17 and 18.

In the past five (5) years, have you, (Dependent 02) consulted a health care provider, received treatment (including prescription medications) or been hospitalized for any of the following conditions or diseases?

G1.	<b>Eyes, Ears, Nose and Throat Conditions/Disorders:</b> <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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G2.	<b>Skin Conditions/Disorders:</b> Acne, psoriasis, keratosis Birthmarks, dermatitis, eczema, fungal infections, warts, herpes, excessive sweating Moles/pre-cancerous lesions, skin cancer, or melanoma 2nd or 3rd degree burns, scars/keloid, or revisions of cosmetic or reconstructive surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G3.	<b>Musculoskeletal Conditions/Disorders:</b> Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as: Strain/sprain, fibromyalgia, gout Fracture, internal/external fixations, permanent hardware, amputation/prosthesis Arthritis, joint replacement, herniated disc, back or neck pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G4.	<b>Respiratory Conditions/Disorders:</b> Allergies, sinusitis, bronchitis, asthma, pneumonia, collapsed lung, spitting/coughing up blood Shortness of breath, chronic cough, emphysema, COPD, difficulty breathing Tuberculosis, fungal infections	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G5.	<b>Digestive Conditions/Disorders:</b> Infections of mouth/throat/tonsils Problems with jaw or chewing, ulcers, hernia, gastric reflux, unexplained weight loss or gain, eating disorder, Gastric Bypass/Banding 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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G6.	<b>Urinary Conditions/Disorders:</b> Bladder infections, kidney infections, stones, blood in urine Stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G7.	<b>Heart and Circulatory Conditions/Disorders:</b> Anemia, bleeding/clotting disorders, Hemophilia, thrombocytopenia, Varicose/spider veins, Raynauds, phlebitis, thrombosis, enlarged lymph nodes or lymphadenitis High blood pressure (hypertension), low blood pressure, high cholesterol/lipids Chest pain, angina, heart murmur, palpitations, congestive heart failure, coronary artery disease, rheumatic fever Heart attack, bypass surgery/angioplasty, valve replacement, prolapsed or leaky valve, pacemaker or defibrillator, aneurysm	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G8.	<b>Metabolic and Endocrine Conditions/Disorders:</b> Diabetes, Insulin Resistance, Metabolic Syndrome, Thyroid disorders Adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis Or other immune disorder (not including the result for the HIV test)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G9.	<b>Brain/Nervous System Conditions/Disorders:</b> Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, narcolepsy, sleep apnea Confusion, memory loss, Alzheimer's, dementia, head injury, seizures/epilepsy Stroke, paralysis, migraine headaches or chronic severe headaches Tremors, Multiple Sclerosis, Muscular Dystrophy, Reflex Sympathetic Dystrophy (RSD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

continued

Applicant's Social Security Number									

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### G. Health History Health History for Dependent 02 (Continued)

G10.	<b>Male Reproductive Conditions/Disorders:</b> a) Fertility/infertility, low sperm count, sexual dysfunction Erectile dysfunction, enlarged prostate, prostatitis, undescended testes Genital or anal herpes/warts, sexually transmitted diseases b) Are you 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G11.	<b>Female Reproductive Conditions/Disorders:</b> a) Pelvic pain, abnormal menstrual bleeding, endometriosis, ovarian cysts, absence of menstruation Abnormal PAP smear, uterine fibroids, fertility/infertility, miscarriage, genital warts/herpes or sexually transmitted diseases Breast cysts/lumps/fibroids, breast implants b) Has it been more than 40 days since you had your last menstrual period? If "Yes," check one: <input type="checkbox"/> Menopause <input type="checkbox"/> Birth Control <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Other (provide reason): _____ c) Have you had an abnormal PAP smear? If "Yes," provide details on <b>Page 17</b> . Date of last normal PAP smear. Date: _____ d) Are you currently pregnant, tested positive with a home pregnancy test, or in the process of adoption or using a surrogate?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G12.	<b>Nervous, Mental and Behavioral:</b> Depression, anxiety, obsessive-compulsive or panic disorders, eating disorders, anorexia/bulimia Attention deficit, chemical imbalance, bi-polar, schizophrenia Substance abuse, counseling or support group, alcohol or chemical dependence	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G13.	<b>Cancer/Tumors:</b> Cysts, tumors or abnormal growths Hodgkin's disease, leukemia or any other cancer or malignancy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G14.	<b>Birth Defects/Congenital Abnormalities:</b> Cerebral Palsy, Birthmarks, developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation Cleft palate/lip, club foot, webbed fingers/toes, skull/facial or other physical deformities	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G15.	In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G16.	In the past 5 years, have you ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: _____ Date Discontinued: _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G17.	Have you consumed any alcoholic beverage in the past 6 months? (Amount: A drink is 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor.) Type: _____ Amount: _____ _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G18.	In the past 5 years, have you been convicted of a DUI (drunk driving violation)? If "Yes," provide state(s) and date(s). Name: _____ State: _____ Date: _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G19.	In the past 5 years, have you been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), or ARC (Aids Related Complex)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G20.	In the past five (5) years, have you received any lab results, X-rays, MRI or other diagnostic test results or physical exam results from a physician or medical practitioner that were considered <b>abnormal</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G21.	In the past 5 years, have you 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 <input type="checkbox"/> Not Sure

continued



Applicant's Social Security Number									

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### G. Health History Health History for Dependent 02 (Continued)

G22.	In the past 5 years, have you been a patient in an outpatient clinic, surgical center, urgent care, treatment center or inpatient in a hospital or other medical facility for any reason other than pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G23.	Are you a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G24.	Are you 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 <input type="checkbox"/> Not Sure
G25.	Have you smoked or used tobacco products, such as snuff and/or chewing tobacco, in the past 12 months? Date Stopped: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G26.	Have you taken prescription medications or been advised to take prescription medications in the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G27.	Within the past two (2) years, have you seen a health care provider (physician, physicians assistant, nurse practitioner, chiropractor, physical therapist or any licensed provider) <b>not already disclosed on this application</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
G28.	Within the past two (2), years have you had any change in your health status, an illness, or injury not mentioned on your application <b>that you have NOT seen a health care provider for</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
<b>NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.</b>		
<b>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.</b>		

### Medical History and Treatment History for Dependent 02

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

<b>If you have answered "Yes" to any of the questions in Section G, you must provide detailed information below.</b>	
Question Number: _____	
Name of Condition/Illness: _____	
Date of Onset/Treatment (mm/yyyy): _____ Date ended: _____ <input type="checkbox"/> Still under treatment	
Treatment(X-ray, Labs, surgical procedure, therapy): _____	
Name of Hospital, clinic or Health Care Provider: _____	
Address: _____	
City: _____ State: _____ ZIP: _____	
Telephone Number: (____) _____	
Question Number: _____	
Name of Condition/Illness: _____	
Date of Onset/Treatment (mm/yyyy): _____ Date ended: _____ <input type="checkbox"/> Still under treatment	
Treatment(X-ray, Labs, surgical procedure, therapy): _____	
Name of Hospital, clinic or Health Care Provider: _____	
Address: _____	
City: _____ State: _____ ZIP: _____	
Telephone Number: (____) _____	
Question Number: _____	
Name of Condition/Illness: _____	
Date of Onset/Treatment (mm/yyyy): _____ Date ended: _____ <input type="checkbox"/> Still under treatment	
Treatment(X-ray, Labs, surgical procedure, therapy): _____	
Name of Hospital, clinic or Health Care Provider: _____	
Address: _____	
City: _____ State: _____ ZIP: _____	
Telephone Number: (____) _____	

continued

Applicant's Social Security Number									

Application ID Number									

**G. Health History for Dependent 02 (Continued)**

**Medical History and Treatment History for Dependent 02**

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

**If you have answered "Not Sure" to any of the questions in Section G, you must provide detailed information below.**

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

☐ Do not understand the medical terms used

☐ Do not understand the question

☐ Do not know if you have the listed condition

☐ Had or have the listed condition but cannot remember details

**Provide any additional information to explain why you answered "Not Sure"**

\_\_\_\_\_

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

☐ Do not understand the medical terms used

☐ Do not understand the question

☐ Do not know if you have the listed condition

☐ Had or have the listed condition but cannot remember details

**Provide any additional information to explain why you answered "Not Sure"**

\_\_\_\_\_

Question Number: \_\_\_\_\_

Name of Condition/Illness: \_\_\_\_\_

☐ Do not understand the medical terms used

☐ Do not understand the question

☐ Do not know if you have the listed condition

☐ Had or have the listed condition but cannot remember details

**Provide any additional information to explain why you answered "Not Sure"**

\_\_\_\_\_

**Medication or Pharmacy History for Dependent 02**

List all medications prescribed and/or taken in the past twelve (12) months

Medication Name (i.e. Ativan)	Frequency and route (i.e. daily/oral)	Condition for which medication was prescribed	Date Prescribed (mm/yyyy)	Date Stopped (mm/yyyy)	Still Taking
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>



Applicant's Social Security Number									

Application ID Number									

**K. Statement of Accountability - To be completed if the applicant cannot complete the application.**

I \_\_\_\_\_ in representation of the applicant, acting as \_\_\_\_\_  
(describe your relationship) have personally read this form to the applicant and completed the application because:

☐ Applicant does not have sufficient command of the English language to complete this application

☐ Applicant is legally incapacitated and unable to complete this application

I have read and explained in detail the contents of this application.

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If translated, I also fully explained the "Conditions and Agreement" under **Section O** to the applicant.

Signature of Representative **(Required)**: \_\_\_\_\_ Today's Date **(Required)**: \_\_\_\_\_

Print Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, Zip Code, State: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**L. Insurance Producer Attestation - To be completed by Insurance Producer/General Agent**

1. Did you see the proposed applicant (and spouse/domestic partner, if applying) at the time this application was executed? If "No," please explain:		<b>General Agent</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Insurance Broker</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. To the best of your knowledge, is the information on this application complete and accurate? If "No," please explain:		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If you willfully state as true any material fact you know to be false, you shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to \$10,000.</b>					
3. You have explained in easy to understand English (or via translation where applicable) the risk to the applicant of providing inaccurate information on this application, and that the applicant fully understands your explanation.		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Signature of Insurance Producer (Required)</b>			<b>Signature of General Agent (Required, if applicable)</b>		
Date	E-mail Address		Date	E-mail Address	
Name of Insurance Producer or Agency to be assigned as Broker of Record (print name)			Name of General Agent (print name)		
TIN Insurance Producer or Agency to be assigned as Broker of Record			Agent TIN Number		
Street Address (Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)			Street Address (Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)		
Telephone Number ( )	Fax Number ( )		Telephone Number ( )	Fax Number ( )	

**M. Aetna Sales Representative**

Last Name of Sales Representative (print name) <b>Mattozzi</b>	First Name of Sales Representative (print name) <b>Marcia</b>
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Applicant's Social Security Number									
Application ID Number									

## N. Instructions

To avoid delays in underwriting, please review this application for missing or incomplete information such as:

- Height and Weight
- Date of Birth
- Physician's address and phone number
- Complete mailing address information, including: city, state and ZIP code
- Complete answers to all Health History questions
- First and Recurring payment options
- Social Security Number for each applicant on **Page 2, Section B**

If additional information or explanation is necessary, attach extra sheets to the back of this application. **All attachments must include primary Applicants Last Name, First Name and be signed and dated.**

## O. 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 spouse/domestic partner and/or 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 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.
3. I authorize Aetna to request Applicant(s) medical records, any prescribed medication history and any other medical or pharmaceutical information to process this application and to make a decision on the approval or disapproval of this 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 Applicant(s) that are applying for coverage under this application to disclose the information required by Aetna and described above to Aetna and/or its designated agents. I understand that I may revoke this authorization at any time while Aetna is determining eligibility for the coverage requested. To do so, I must notify Aetna in writing prior to the issuance of the policy. Revocation of this authorization will result in closure of this application.
4. 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 persons applying for coverage; 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 authorize Aetna to use such information and to disclose such information to affiliates, Providers, payers, 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. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that Aetna will comply with the HIPAA Privacy Rules and that disclosure of such information will be done in accordance with applicable law.
5. I understand that I am entitled, as is any authorized representative that I may designate, to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
6. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice.
7. **Attention California Residents: For your protection**, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison

Applicant's Social Security Number									

Application ID Number									

**P. Signature(s) Required - All persons applying for coverage age 18 and over must sign and date below.**

I understand that if my signature/date do not appear and/or are not current and/or my answers are incomplete this application will be declined.

I have an obligation of communicating to Aetna in writing any medical conditions which occur to Applicant(s) listed in this application after the signature date on this application and before the effective date of the coverage, if approved.

I understand that 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.

**By signing below, Applicant(s) agree to the statements listed above on this application and represent that all information supplied on this form is true and complete to the best of their knowledge. Applicant(s) have read, understand, and agree to the conditions of enrollment on this application. Applicant(s) understand that the information supplied in this form will be decisive for the approval of this application and that any intentional misrepresentation and/or mistake in such information will be reason for cancellation/termination of the coverage for which Applicant(s) are applying.**

**If adding dependents: I represent that the child/children listed on this form are my dependents.**

**I understand that Aetna requires a copy of my child's birth certificate, adoption decree or legal documentation of responsibility for purposes of dependent verification.**

**NOTE: Failure to provide such documentation within 60 days of the date of birth or adoption (unless otherwise required by the state) will be grounds for termination/cancellation of the coverage for the newborn or adopted child/children listed above and all claims incurred will become the financial responsibility of the undersigned member.**

<b>Applicant's Signature</b>	Today's Date
<b>Applicant's Spouse/Domestic Partner</b> (If applying for coverage)	Today's Date
<b>Applicant's Dependent</b> (Not a minor)	Today's Date
<b>Applicant's Dependent</b> (Not a minor)	Today's Date

**Q. Contact Information**

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

<b>Aetna Advantage Plans</b> <b>PO Box 14381</b> <b>Lexington, KY, 40512-4381</b>	<b>Fax #: 866-892-8396</b> <b><u><a href="http://www.aetna.com/members/individuals">www.aetna.com/members/individuals</a></u></b>
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**R. DMHC Written Notice of Availability of Language Assistance**

**HMO and DMO-based plans - IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-877-287-0117.

**Planes basados en DMO y HMO - IMPORTANTE:** ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

Applicant's Social Security Number									
Application ID Number									

## S. Traditional Plans

**No Cost Language Services.** You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-877-287-0117. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

**Servicios de idiomas sin costo.** Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-877-287-0117. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

**免費語言服務。** 您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-877-287-0117 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

**Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí.** Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-877-287-0117. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

**무료 통역 서비스.** 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-877-287-0117번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

**Walang Gastos na mga Serbisyo sa Wika.** Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-877-287-0117. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

**Անվճար Լեզվախոս Օգնականություններ:** Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել սույն ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) ստմնի վրա նշված կամ 1-877-287-0117 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆոռնիայի Ապահովագրության Բաժանմունք: Armenian

**Бесплатные услуги перевода.** Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-877-287-0117. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

**無料の言語サービス** 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-877-287-0117までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجاني مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-877-287-0117 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

**ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ:** ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-877-287-0117 'ਤੇ ਸਾਨ ਫ਼ਨ ਕਰੋ। ਵਧੇਰ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੂਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

**សេវាកម្មភាសាឥតគិតថ្លៃ** ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកលើអ្វីៗតាមលេខដែលមាន បង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-877-287-0117 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាស៊ីហ្គីញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-877-287-0117. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 Arabic

**Cov Kev Pab Txhais Lus Tsis Them Nqi.** Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-877-287-0117. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong