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

(PLEASE NOTE: HIPAA ELIGIBLE APPLICANTS WILL NOT BE DENIED COVERAGE) TO COMPLY WITH CALIFORNIA LAW, WHEREVER THE TERM "SPOUSE/DOMESTIC PARTNER" APPEARS IT SHALL BE CONSTRUED TO INCLUDE DOMESTIC PARTNER. Instructions and Important Information:

- Please PRINT clearly. Application must be completed by the Applicant in blue or black ink. No pencil or correction fluid. (A photocopy of this application will not be accepted.)
- The Applicant must complete the application. You are responsible to ensure that the information on the application is correct, complete, and truthful.
- Any intentional misrepresentation of information on the application may result in cancellation of coverage.
- The application must be received by Aetna's underwriting department within 30 days from the signature date.
- You are ineligible for coverage, if as a non-citizen of the United States, you have not resided in the U.S. for six (6) consecutive months.
- This application must be completed in its entirety and one (1) form of payment selected or processing time will be delayed.
- Your insurance will become effective only if this application is approved as applied for, and the appropriate premium is enclosed.
- Coverage is not guaranteed until approved in writing by Aetna. DO NOT cancel your current insurance coverage until you have been notified of your approval by Aetna and your Aetna coverage is in effect.
- Signature and date is required on Page 22, Section P for all applicants including spouse/domestic partner (DP) and children age 18 and over.
- Underwritten by Aetna Life Insurance Company.
- Once you submit this application, you may be contacted at any time via telephone by an Aetna representative to complete your application and the underwriting process. Please do not answer any questions if you are not satisfied with the identity of the caller. Please call **1-866-898-3267** if you have any questions or concerns.

A. Applicant Information

Name					
Mailing Address (All Aetna correspondence will be sent to this address) – Include Apartment Number, if applicable. Number, Street County City, State, ZIP Code	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				
Telephone Numbers					
Home () Work ()	Cell ()				
Marital Status Occupation	E-mail Address	Do you read and write			
		English?			
Domestic Partner		🗌 Yes 🔝 No			
Choose desired benefit plan type:	Reason for Application:				
Managed Choice Open Access:	New Enrollment for Aetna Advantage Plans Add Spouse/Domestic Partner/Dependent Child to an Existing Plan				
Managed Choice Open Access Value:	Add Dependent Child To An Existing Plan	ne Plan Member Only)			
2500 5000 8000 8000 10000 1000 1000 1000 1000 100000 100000 10000 100000 100000 100000 100000 100000 100000 100000 1000000	Change Existing Benefit Plan (Existing Advantage Plan Member Only)				
High Deductible 3500 (HSA Compatible)					
Preventive and Hospital Care 2750 (HSA Compatible)					
MCOA 7500 with Unlimited Primary Care Visits plus Dental					
Dental (Dental option available only with choice of medical plan above.)					
Please check if applicable: I am eligible for health benefits offered	by my employer I am a sole proprietor	or I am self-employed			
Is any person listed on this application 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.					

*In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans.

Applicant's Social Security Number							
Арр	Application ID Number						

Send completed Application to: Aetna Advantage Plans PO Box 14381 Lexington, KY 40512-4381



Applicant's Social Security Number							
Applica	ation	ID N	lumbe	er			

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	Name			Social Security	Date of Birth		Sex	Height	Weight
Code	Last	First	M.I.	Number	(MM/DD/YYYY)	Age	(M/F)	(ft/in)	(lbs)
APP	Applicant								
SP	Spouse/Don	nestic Partner							
01	Dependent								
02	Dependent								
C. Othe	r Insurance	– Please attach copy of C	Continuation of Cove	rage Certificate letter fo	or each applicant, i	f applica	ble.	L	
Do you o	currently hav	e any health care coverage	? 🗌 Yes 🗌 N	lo Are your spouse/do	mestic partner/childr	en cover	ed also?	🗌 Yes	🗌 No
Provide Name:	name of curr	ent (or most recent) health	care carrier and cover	rage termination date (if a	applicable). Term Date:				
-	family memb	ers listed above currently e	enrolled in an Aetna Pl	an?					
	No	If "Yes," provide the follow							
		Name(s):	-	Relationship:	ID N	0.:			
	person listed	d on this application ever b	een declined, postpon	ed, had a waiver applied	or charged an additi	ional prei	mium for	life, disabil	ity or
🗌 Yes	🗌 No	If "Yes," provide the follow Name:	•						
		Explanation:							
Has any	person listed	d on this application had the	eir health insurance re	scinded?					
Yes		If "Yes," provide the follow							
		Name:							
		Date:							
		Explanation:							
	•	d on this application ever fil		eived benefits from disabi	ility insurance or Wo	rkers' Co	mpensat	ion?	
🗌 Yes	🗌 No	If "Yes," provide the follow	•						
		Name: Date:							
		Explanation:							
Are any	persons liste	d above eligible for Medica	ire?						
Yes	•	Name:							

Health History

Each applicant must complete a separate Health History section.

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.

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.

	Applicant's Social Se	curity Number
	Application ID Numb	er
	Applicant Name	
D. He	alth History for Primary Applicant	
	answer "Yes" or "Not Sure" on any of the questions below, provide details on Pages 5 and 6.	
	past five (5) years, have you the primary applicant consulted a health care provider, received treatment (including p	rescription
	cations) or been hospitalized for any of the following conditions or diseases?	
D1.	Eyes, Ears, Nose and Throat Conditions/Disorders:Eyes/sight:• Glaucoma, cataracts, crossed eyes, detached retina, corneal transplant, infectionsEars/Hearing:• Loss of hearing, deafness, infections, eustachian tube dysfunctionNose/breathing:• Deviated septum, polyps, adenoiditis, sinusitisThroat/Swallowing:• Tonsillitis, strep throat, excessive snoring or sleep apnea	└ Yes
D2.	Skin Conditions/Disorders: 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	☐ Yes ☐ No ☐ Not Sure
D3.	Musculoskeletal Conditions/Disorders: 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	Yes No
D4.	Respiratory Conditions/Disorders: Allergies, sinusitis, bronchitis, asthma, pneumonia, collapsed lung, spitting/coughing up blood Shortness of breath, chronic cough, emphysema, COPD, difficulty breathing Tuberculosis, fungal infections	Yes No
D5.	Digestive Conditions/Disorders: 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	☐ Yes ☐ No ☐ Not Sure
D6.	Urinary Conditions/Disorders: Bladder infections, kidney infections, stones, blood in urine Stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting	Yes No
D7.	Heart and Circulatory Conditions/Disorders: 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	Yes No
D8.	Metabolic and Endocrine Conditions/Disorders: 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)	☐ Yes ☐ No ☐ Not Sure
D9.	Brain/Nervous System Conditions/Disorders: 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)	Yes No

Applicant's Social Security Number							
Арр	licatio	on ID	Nun	nber			

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

D10.	Male Reproductive Conditions/Disorders:	
	a) Fertility/infertility, low sperm count, sexual dysfunction	Not Sure
	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?	Yes No
D11.	Female Reproductive Conditions/Disorders:	
	a) Pelvic pain, abnormal menstrual bleeding, endometriosis, ovarian cysts, absence of menstruation	Not Sure
	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:	Yes No
	Menopause Birth Control Hysterectomy	Not Sure
	Other (provide reason):	
	c) Have you had an abnormal PAP smear? If "Yes," provide details on Page 5. Date of last normal PAP smear.	Yes No
	Date:	Not Sure
	d) Are you currently pregnant, tested positive with a home pregnancy test, or in the process of adoption or using a	🗌 Yes 🗌 No
	surrogate?	Not Sure
D12.	Nervous, Mental and Behavioral:	🗌 Yes 🗌 No
	Depression, anxiety, obsessive-compulsive or panic disorders, eating disorders, anorexia/bulimia	Not Sure
	Attention deficit, chemical imbalance, bi-polar, schizophrenia	
D 40	Substance abuse, counseling or support group, alcohol or chemical dependence	
D13.	Cancer/Tumors: Cysts, tumors or abnormal growths	
	Hodgkin's disease, leukemia or any other cancer or malignancy	Not Sure
	······	
D14.	Birth Defects/Congenital Abnormalities:	Yes No
D14.	Birth Defects/Congenital Abnormalities: Cerebral Palsy, Birthmarks, developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation	Yes No
	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	Not Sure
D14. D15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to	Not Sure
D15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake?	Not Sure
	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? In the past 5 years, have you ever used illegal or controlled drugs or substances, such as marijuana, cocaine,	Not Sure Yes No Not Sure Not Sure Yes No
D15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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?	Not Sure
D15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? In the past 5 years, have you ever used illegal or controlled drugs or substances, such as marijuana, cocaine,	Not Sure Yes No Not Sure Not Sure Yes No
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D15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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?	Not Sure Yes No Not Sure Not Sure Yes No
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D15. D16. D17.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	Not Sure Yes No Yes No Yes No Not Sure Yes No Not Sure Yes No Not Sure
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D15. D16. D17.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	Not Sure Yes No Yes No Yes No Not Sure Yes No Not Sure Yes No Not Sure
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D15. D16. D17.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	Not Sure Yes Not Sure Yes Not Sure Yes Not Sure Yes Not Sure Yes Not Sure Yes Not Sure
D15. D16. D17. D17.	Cerebral Palsy, Birtmarks, 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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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: 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: Menut: per Day Week Month In the past 5 years, have you been convicted of a DUI (drunk driving violation)? If "Yes," provide state(s) and date(s). Name: N	Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure
D15. D16. D17. D17. D18.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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: 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: Mamount: per Day Week Month per Day Week Month In the past 5 years, have you been convicted of a DUI (drunk driving violation)? If "Yes," provide state(s) and date(s). Name: Name: Name: Name: Mathematical or substance of the past 5 years, have you been diagnosed as having or received treatment by a physician or health care provider for	Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure
D15. D16. D17. D17. D18.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	Not Sure Yes Not Sure Yes Not Sure Yes Not Sure Yes Not Sure Yes Not Sure Yes Not Sure Yes Not Sure Yes Not Sure Yes Not Sure Yes Not Sure Yes Not Sure

Applicant's Social Security Number								
Арр	Application ID Number							

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, tre in a hospital or other medical facility for any reason other than pregnancy?	atment center or inpatien	t 🗌 Yes 🗌 No
D23.	Are you a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?		Yes No
D24.	Are you currently on the donor waiting list and/or registered to donate an organ or bone marrow (ex	xcluding DMV card)?	Yes No
D25.	Have you smoked or used tobacco products, such as snuff and/or chewing tobacco, in the past 12 Date Stopped:	months?	Yes No
D26.	Have you taken prescription medications or been advised to take prescription medications in the particular sector of the	ast 2 years?	Yes No
D27	Within the past two (2) years, have you seen a health care provider (physician, physicians assistar chiropractor, physical therapist or any licensed provider) not already disclosed on this application		Yes No
D28	Within the past two (2), years have you had any change in your health status, an illness, or injury r application that you have NOT seen a health care provider for ?	ot mentioned on your	Yes No
NOTIO	CE: California law prohibits an HIV test from being required or used by health insurance con insurance coverage.	npanies as a condition of	of obtaining health
NOTE	E: Medical conditions that occur after the signature date and before the effective date of the the final underwriting decision. You shall communicate any medical condition occurring of the section.		ill be considered in
	cal History and Treatment History for the Primary Applicant heck here if more space is needed. Use a separate sheet of paper and staple to the back of th	is application.	
	ا have answered "Yes" to any of the questions in Section D, you must provide detailed inform		
Quest	tion Number:		
Name	e of Condition/IIIness:		
Date c	of Onset/Treatment (mm/yyyy): Date ended:		Still under treatment
	ment(X-ray, Labs, surgical procedure, therapy):		
Name	e of Hospital, clinic or Health Care Provider:		
Addres	9995:		
City:	State:	ZIP:	
Teleph	hone Number: ()		
	tion Number:		
	e of Condition/Illness:		
	of Onset/Treatment (mm/yyyy): Date ended:		Still under treatment
	ment(X-ray, Labs, surgical procedure, therapy):		
	e of Hospital, clinic or Health Care Provider:		
	ess:	715	
	State:	ZIP:	<u> </u>
relepr	hone Number: ()		
Quest	tion Number:		
	e of Condition/Illness:		
	of Onset/Treatment (mm/yyyy): Date ended:		Still under treatment
	ment(X-ray, Labs, surgical procedure, therapy):		
	e of Hospital, clinic or Health Care Provider:		
	2955:		
Citv:	State:	ZIP:	
	hone Number: ()		
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Applicant's Social Security Number						
Арр	licatio	on ID	Nun	nber		

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

			Applicant's Social Se	ecurity Number
		l I	Application ID Numb	
			Application ID Numb	er
		Spouse/Domestic Partner Name)	
E. He	alth History for Spouse/Domestic Partner			
lf you	answer "Yes" or "Not Sure" on any of the questions below, provi	ide details on Pages 9 and 10.		
	past five (5) years, have you, (Spouse/Domestic Partner) consult ations) or been hospitalized for any of the following conditions o		ed treatment (includ	ling prescription
E1.	Eyes, Ears, Nose and Throat Conditions/Disorders:	0 UISE85ES :		Yes No
L 1.	<i>Eyes/sight:</i> • Glaucoma, cataracts, crossed eyes, detache	d retina corneal transplant infectio	ons	Not Sure
	<i>Ears/Hearing:</i> • Loss of hearing, deafness, infections, eustac			
	Nose/breathing: • Deviated septum, polyps, adenoiditis, sinusit			
	Throat/Swallowing: • Tonsillitis, strep throat, excessive snoring or s	sleep apnea		
E2.	Skin Conditions/Disorders:			🗌 Yes 🗌 No
	Acne, psoriasis, keratosis			Not Sure
	Birthmarks, dermatitis, eczema, fungal infections, warts, herpes, exce	essive sweating		
	Moles/pre-cancerous lesions, skin cancer, or melanoma			
50	2nd or 3rd degree burns, scars/keloid, or revisions of cosmetic or rec		de la contra de la c	
E3.	Musculoskeletal Conditions/Disorders: Disorders or injuries of bo	nes, joints, muscles, ligaments, ten	idons or discs such	
	as: Strain/sprain, fibromyalgia, gout Fracture, internal/external fixations, permanent hardware, amputatior	prosthosis		Not Sure
	Arthritis, joint replacement, herniated disc, back or neck pain	i/prostnesis		
E4.	Respiratory Conditions/Disorders:			Yes No
LT.	Allergies, sinusitis, bronchitis, asthma, pneumonia, collapsed lung, sp	pittina/coughing up blood		Not Sure
	Shortness of breath, chronic cough, emphysema, COPD, difficulty breath			
	Tuberculosis, fungal infections	·		
E5.	Digestive Conditions/Disorders:			🗌 Yes 🗌 No
	Infections of mouth/throat/tonsils			Not Sure
	Problems with jaw or chewing, ulcers, hernia, gastric reflux, unexplain	ned weight loss or gain, eating diso	rder, Gastric	
	Bypass/Banding Colitis, Crohn's Disease, Irritable Bowel Syndrome (IBS), chronic diar	rrhad intestinal problems cales as	lung rootal blooding	
	or hemorrhoids	intea, intestinal problems, colori po	Typs, rectar bleeding	
	Diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other,	jaundice, Cirrhosis		
E6.	Urinary Conditions/Disorders:			🗌 Yes 🗌 No
	Bladder infections, kidney infections, stones, blood in urine			Not Sure
	Stress incontinence, urinary frequency, painful/difficult urination, cysti	tis, bed wetting		
E7.	Heart and Circulatory Conditions/Disorders:			🗌 Yes 🔲 No
	Anemia, bleeding/clotting disorders, Hemophilia, thrombocytopenia, \	Varicose/spider veins, Raynauds, p	hlebitis, thrombosis,	Not Sure
	enlarged lymph nodes or lymphadenitis	e vel/lizide		
	High blood pressure (hypertension), low blood pressure, high cholest Chest pain, angina, heart murmur, palpitations, congestive heart failu		atic four	
	Heart attack, bypass surgery/angioplasty, valve replacement, prolaps			
E8.	Metabolic and Endocrine Conditions/Disorders:		· · · ·	Yes No
	Diabetes, Insulin Resistance, Metabolic Syndrome, Thyroid disorders	6		Not Sure
	Adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndr	ome, Epstein-Barr, mononucleosis		
	Or other immune disorder (not including the result for the HIV test)			
E9.	Brain/Nervous System Conditions/Disorders:			🗌 Yes 🔲 No
	Loss of consciousness, fainting, dizziness, numbness/tingling, weakn			Not Sure
	Confusion, memory loss, Alzheimer's, dementia, head injury, seizures	s/epilepsy		
	Stroke, paralysis, migraine headaches or chronic severe headaches	Dustranby (BSD)		
	Tremors, Multiple Sclerosis, Muscular Dystrophy, Reflex Sympathetic	(Lon)		

Applicant's Social Security Number

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

F 40		
E10.	Male Reproductive Conditions/Disorders:	🗌 Yes 🗌 No
	a) Fertility/infertility, low sperm count, sexual dysfunction	Not Sure
	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?	☐ Yes ☐ No ☐ Not Sure
E11.	Female Reproductive Conditions/Disorders:	🗌 Yes 🗌 No
	a) Pelvic pain, abnormal menstrual bleeding, endometriosis, ovarian cysts, absence of menstruation	Not Sure
	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:	🗌 Yes 🗌 No
	Menopause Birth Control Hysterectomy	Not Sure
	Other (provide reason):	
	c) Have you had an abnormal PAP smear? If "Yes," provide details on Page 9. Date of last normal PAP smear.	🗌 Yes 🔲 No
	Date:	Not Sure
	d) Are you currently pregnant, tested positive with a home pregnancy test, or in the process of adoption or using a	🗌 Yes 🔲 No
	surrogate?	Not Sure
E12.	Nervous, Mental and Behavioral:	🗌 Yes 🔲 No
	Depression, anxiety, obsessive-compulsive or panic disorders, eating disorders, anorexia/bulimia	Not Sure
	Attention deficit, chemical imbalance, bi-polar, schizophrenia Substance abuse, counseling or support group, alcohol or chemical dependence	
E13.	Cancer/Tumors:	Yes No
L 10.	Cysts, tumors or abnormal growths	Not Sure
	Hodgkin's disease, leukemia or any other cancer or malignancy	
E14.	Birth Defects/Congenital Abnormalities:	🗌 Yes 🗌 No
	Cerebral Palsy, Birthmarks, developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation	Not Sure
F 45	Cleft palate/lip, club foot, webbed fingers/toes, skull/facial or other physical deformities	
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?	Yes INo
E16.	In the past 5 years, have you ever used illegal or controlled drugs or substances, such as marijuana, cocaine,	
L 10.		Yes No
L 10.	methamphetamines, illegal, or controlled IV drugs?	
L 10.	methamphetamines, illegal, or controlled IV drugs?	Yes No
	methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: Date Discontinued:	Yes No
	methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: Date Discontinued:	Yes □ No Not Sure Yes □ No
	methamphetamines, illegal, or controlled IV drugs? Date Discontinued: Type of Drug/Substance: Date Discontinued: 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.)	Yes No
	methamphetamines, illegal, or controlled IV drugs? Date Discontinued: Type of Drug/Substance:	Yes □ No Not Sure Yes □ No
	methamphetamines, illegal, or controlled IV drugs? Date Discontinued: Type of Drug/Substance:	Yes □ No Not Sure Yes □ No
E17.	methamphetamines, illegal, or controlled IV drugs? Date Discontinued: Type of Drug/Substance:	Yes No Not Sure Yes No Not Sure No Not Sure
	methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: Date Discontinued:	Yes □ No Not Sure Yes □ No Not Sure Not Sure Yes □ No
E17.	methamphetamines, illegal, or controlled IV drugs? Date Discontinued: Type of Drug/Substance:	Yes No Not Sure Yes No Not Sure No Not Sure
E17.	methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: Date Discontinued:	Yes □ No Not Sure Yes □ No Not Sure Not Sure Yes □ No
E17.	methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: Date Discontinued: 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 Day Week Month per Day Week Month nt he past 5 years, have you been convicted of a DUI (drunk driving violation)? If "Yes," provide state(s) and date(s). Name: State: Date: Date: In the past 5 years, have you been diagnosed as having or received treatment by a physician or health care provider for	Yes □ No Not Sure Yes □ No Not Sure Not Sure Yes □ No
E17. E18. E19.	methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: Date Discontinued: 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 Day Week Month per Date 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)?	Yes No Not Sure Yes No Not Sure Yes No Yes No Yes No Yes No Yes No Not Sure Not Sure Yes No Not Sure No Not Sure No
E17. E18.	methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: Date Discontinued: 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 Day Week Month per Day Week Month nt he past 5 years, have you been convicted of a DUI (drunk driving violation)? If "Yes," provide state(s) and date(s). Name: State: Date:	Yes No Not Sure Yes No Not Sure Yes No Yes No Yes No Not Sure Yes No Not Sure Yes No Yes No Yes No Yes No Yes No Yes No
E17. E18. E19. E20.	methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: Date Discontinued:	Yes No Not Sure Yes No Yes No Not Sure Yes No Yes No Yes No Yes No Yes No Not Sure Yes No Not Sure Not Sure Not Sure Not Sure
E17. E18. E19.	methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: Date Discontinued: 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 Day Week Month per Day Week Month nt he past 5 years, have you been convicted of a DUI (drunk driving violation)? If "Yes," provide state(s) and date(s). Name: State: Date:	Yes No Not Sure Yes No Yes No Not Sure Yes No Yes No Yes No Yes No Yes No Not Sure Yes No Not Sure Not Sure Not Sure Not Sure

Applicant's Social Security Number									
Арр	Application ID Number								

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, treatmen in a hospital or other medical facility for any reason other than pregnancy?	nt center or inpatient	☐ Yes ☐ No ☐ Not Sure
E23.			
E23.	Are you a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?		☐ Yes ☐ No ☐ Not Sure
E24.	Are you currently on the donor waiting list and/or registered to donate an organ or bone marrow (excludir	ng DMV card)?	Yes No
E25.	Have you smoked or used tobacco products, such as snuff and/or chewing tobacco, in the past 12 month Date Stopped:	hs?	Yes No Not Sure
E26.	Have you taken prescription medications or been advised to take prescription medications in the past 2 y	/ears?	Yes No
E27	Within the past two (2) years, have you seen a health care provider (physician, physicians assistant, nurs chiropractor, physical therapist or any licensed provider) not already disclosed on this application ?	se practitioner,	Yes No
E28	Within the past two (2), years have you had any change in your health status, an illness, or injury not me application that you have NOT seen a health care provider for ?	ntioned on your	Yes No
NOTIC	CE: California law prohibits an HIV test from being required or used by health insurance companie insurance coverage.	es as a condition of	f obtaining health
NOTE	E: Medical conditions that occur after the signature date and before the effective date of the covera the final underwriting decision. You shall communicate any medical condition occurring during	• • • •	l be considered in
	cal History and Treatment History for Spouse/Domestic Partner heck here if more space is needed. Use a separate sheet of paper and staple to the back of this app	plication.	
	I have answered "Yes" to any of the questions in Section E, you must provide detailed information		
Questi	tion Number:		
Name	e of Condition/IIIness:		
Date o	of Onset/Treatment (mm/yyyy): Date ended:	St	ill under treatment
	ment(X-ray, Labs, surgical procedure, therapy):		
	e of Hospital, clinic or Health Care Provider:		
	ess:		
	State:	ZIP:	
Teleph	hone Number: ()		
Questi	tion Number:		
Name	e of Condition/IIIness:		
Date o	of Onset/Treatment (mm/yyyy): Date ended:	St	ill under treatment
Treatm	ment(X-ray, Labs, surgical procedure, therapy):		
	e of Hospital, clinic or Health Care Provider:		
	ess:		
City:	State:	ZIP:	
	hone Number: ()		
Ouacti	tion Number:		
	e of Condition/Illness:		ill under treetwert
	of Onset/Treatment (mm/yyyy): Date ended:		
	ment(X-ray, Labs, surgical procedure, therapy):		
	e of Hospital, clinic or Health Care Provider:		
Addres	ess:		
City:	State:	ZIP:	
Teleph	hone Number: ()		

Applicant's Social Security Number								
App	licatio	on ID	Nun	nber				

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

			Applicant's Soci	al Security I	Numbe	ər
			Application ID N	lumber		
		Dependent 01 Name				
F. He	alth History for Dependent 01					
	answer "Yes" or "Not Sure" on any of the questions below, provi	-				
	past five (5) years, have you, (Dependent 01) consulted a health on hospitalized for any of the following conditions or diseases?	care provider, received treatme	nt (including pre	scription m	edica	tions)
F1.	Eyes, Ears, Nose and Throat Conditions/Disorders:Eyes/sight:• Glaucoma, cataracts, crossed eyes, detacheEars/Hearing:• Loss of hearing, deafness, infections, eustacNose/breathing:• Deviated septum, polyps, adenoiditis, sinusitiThroat/Swallowing:• Tonsillitis, strep throat, excessive snoring or state	hian tube dysfunction is	tions		es 🗌 ot Sur] No e
F2.	Skin Conditions/Disorders: Acne, psoriasis, keratosis Birthmarks, dermatitis, eczema, fungal infections, warts, herpes, exce Moles/pre-cancerous lesions, skin cancer, or melanoma 2nd or 3rd degree burns, scars/keloid, or revisions of cosmetic or reco	, and the second s		∏ Ye ∏ N	es 🗌 ot Sur] No e
F3.	Musculoskeletal Conditions/Disorders: Disorders or injuries of bo as: Strain/sprain, fibromyalgia, gout Fracture, internal/external fixations, permanent hardware, amputation Arthritis, joint replacement, herniated disc, back or neck pain		endons or discs su		es 🗌 ot Sur] No e
F4.	Respiratory Conditions/Disorders: Allergies, sinusitis, bronchitis, asthma, pneumonia, collapsed lung, sp Shortness of breath, chronic cough, emphysema, COPD, difficulty bre Tuberculosis, fungal infections			☐ Ye ☐ N	es 🗌 ot Sur] No e
F5.	Digestive Conditions/Disorders: Infections of mouth/throat/tonsils Problems with jaw or chewing, ulcers, hernia, gastric reflux, unexplair Bypass/Banding Colitis, Crohn's Disease, Irritable Bowel Syndrome (IBS), chronic diar or hemorrhoids Diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, j	rrhea, intestinal problems, colon p			es 🗌 ot Sur] No e
F6.	Urinary Conditions/Disorders: Bladder infections, kidney infections, stones, blood in urine Stress incontinence, urinary frequency, painful/difficult urination, cysti	tis, bed wetting			es 🗌 ot Sur] No e
F7.	Heart and Circulatory Conditions/Disorders: Anemia, bleeding/clotting disorders, Hemophilia, thrombocytopenia, V enlarged lymph nodes or lymphadenitis High blood pressure (hypertension), low blood pressure, high cholest Chest pain, angina, heart murmur, palpitations, congestive heart failu Heart attack, bypass surgery/angioplasty, valve replacement, prolaps	erol/lipids re, coronary artery disease, rheu	matic fever	osis, 🔲 N	es 🗌 ot Sur] No e
F8.	Metabolic and Endocrine Conditions/Disorders: Diabetes, Insulin Resistance, Metabolic Syndrome, Thyroid disorders Adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndry Or other immune disorder (not including the result for the HIV test)		S		ot Sur	
F9.	Brain/Nervous System Conditions/Disorders: Loss of consciousness, fainting, dizziness, numbness/tingling, weakn Confusion, memory loss, Alzheimer's, dementia, head injury, seizures Stroke, paralysis, migraine headaches or chronic severe headaches Tremors, Multiple Sclerosis, Muscular Dystrophy, Reflex Sympathetic	s/epilepsy			es 🗌 ot Sur] No e

Applicant's Social Security Number									
licatio	on ID	Nun	nber						
	l I	1	ı –	1	1	l i			
				licant's Social Secu lication ID Number					

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

F10.	Male Reproductive Conditions/Disorders:	
	a) Fertility/infertility, low sperm count, sexual dysfunction	Not Sure
	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?	Yes No Not Sure
F11.	Female Reproductive Conditions/Disorders:	Yes No
	a) Pelvic pain, abnormal menstrual bleeding, endometriosis, ovarian cysts, absence of menstruation	Not Sure
	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:	
	Menopause Birth Control Hysterectomy	Not Sure
	Other (provide reason):	
	c) Have you had an abnormal PAP smear? If "Yes," provide details on Page 13 . Date of last normal PAP smear.	
		Not Sure
	d) Are you currently pregnant, tested positive with a home pregnancy test, or in the process of adoption or using a	
540	surrogate?	Not Sure
F12.	Nervous, Mental and Behavioral: Depression, anxiety, obsessive-compulsive or panic disorders, eating disorders, anorexia/bulimia	
	Attention deficit, chemical imbalance, bi-polar, schizophrenia	Not Sure
	Substance abuse, counseling or support group, alcohol or chemical dependence	
F13.	Cancer/Tumors:	Yes No
	Cysts, tumors or abnormal growths	Not Sure
	Hodgkin's disease, leukemia or any other cancer or malignancy	
F14.	Birth Defects/Congenital Abnormalities:	🗌 Yes 🔲 No
F14.	Cerebral Palsy, Birthmarks, developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation	└ Yes └ No └ Not Sure
	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	Not Sure
F14. F15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to	Not Sure
F15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake?	Not Sure Yes No Not Sure
	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? In the past 5 years, have you ever used illegal or controlled drugs or substances, such as marijuana, cocaine,	Not Sure Yes No Not Sure Not Sure Yes No Yes No
F15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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?	Not Sure Yes No Not Sure
F15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? In the past 5 years, have you ever used illegal or controlled drugs or substances, such as marijuana, cocaine,	Not Sure Yes No Not Sure Not Sure Yes No Yes No
F15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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?	Not Sure Yes No Not Sure Not Sure Yes No Yes No
F15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	Not Sure Yes No Not Sure Yes No Not Sure No Not Sure
F15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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?	Not Sure Yes No Not Sure Not Sure Yes No Yes No
F15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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: 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.	 ☐ Not Sure ☐ Yes ☐ No ☐ Not Sure ☐ Yes ☐ No ☐ Not Sure
F15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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: 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.)	 ☐ Not Sure ☐ Yes ☐ No ☐ Not Sure ☐ Yes ☐ No ☐ Not Sure
F15. F16. F17.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	Not Sure Yes No Yes No Yes No Not Sure Yes No Not Sure Yes No Not Sure
F15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	 Not Sure Yes □ No Yes □ No Yes □ No
F15. F16. F17.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	Not Sure Yes No Yes No Not Sure Yes No Yes No Not Sure Yes No Not Sure
F15. F16. F17.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	 Not Sure Yes □ No Yes □ No Yes □ No
F15. F16. F17. F18.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure
F15. F16. F17.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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: 	 Not Sure Yes □ No Not Sure
F15. F16. F17. F18. F19.	Cerebral Palsy, Birtmarks, 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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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: 	 Not Sure Yes □ No Not Sure
F15. F16. F17. F18.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	 Not Sure Yes □ No Yes □ No Yes □ No
F15. F16. F17. F18. F19. F20.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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: 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: Mare 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: Mare you been convicted of a DUI (drunk driving violation)? If "Yes," provide state(s) and date(s). Name: Mare: Mare 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)? 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 abnormal ?	Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Not Sure
F15. F16. F17. F18. F19.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Not Sure

Applicant's Social Security Number									
Арр	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 inpatien in a hospital or other medical facility for any reason other than pregnancy?	ent Yes No
F23.	Are you a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	Yes No
F24.	Are you on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	Yes No
F25.	Have you or used tobacco products, such as snuff and/or chewing tobacco, in the past 12 months? Date Stopped:	Yes No
F26.	Have you taken prescription medications or been advised to take prescription medications in the past 2 years?	Yes No
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) not already disclosed on this application ?	Yes No
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 that you have NOT seen a health care provider for ?	Yes No
NOTI	CE: California law prohibits an HIV test from being required or used by health insurance companies as a condition insurance coverage.	n of obtaining health
NOTE	E: Medical conditions that occur after the signature date and before the effective date of the coverage if approved the final underwriting decision. You shall communicate any medical condition occurring during such period.	will be considered in
	al History and Treatment History for Dependent 01 neck here if more space is needed. Use a separate sheet of paper and staple to the back of this application.	
	have answered "Yes" to any of the questions in Section F, you must provide detailed information below.	
Quest	ion Number:	
Name	of Condition/Illness:	
Date of	of Onset/Treatment (mm/yyyy): Date ended:	Still under treatment
Treatr	nent(X-ray, Labs, surgical procedure, therapy):	
Name	of Hospital, clinic or Health Care Provider:	
	SS:	
	State: ZIP:	
Teleph	none Number: ()	
Quest	ion Number:	
Name	of Condition/Illness:	
Date of	of Onset/Treatment (mm/yyyy): Date ended:	Still under treatment
Treatr	nent(X-ray, Labs, surgical procedure, therapy):	-
	of Hospital, clinic or Health Care Provider:	
	SS:	
	State: ZIP:	
	none Number: ()	
Quant	ion Number:	
	of Condition/Illness: Date ended: Date ended:] Still under treatment
	nent(X-ray, Labs, surgical procedure, therapy):	
	e of Hospital, clinic or Health Care Provider:	
Citur	SS:State:7ID:	
-	State: ZIP:	
relept	hone Number: ()	

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

			Applica	anťs S	ocial S	ecuri	ty Num	ber
			Applica	ation ID) Num	ber		
G He	alth History for Dependent 02	Dependent 02 Name						
	answer "Yes" or "Not Sure" on any of the questions below, provi	de details on Pages 17 and 18	3.					
	past five (5) years, have you, (Dependent 02) consulted a health or hospitalized for any of the following conditions or diseases?	care provider, received treatm	ent (inclu	iding p	orescri	iption	medic	ations)
G1.	Eyes, Ears, Nose and Throat Conditions/Disorders:Eyes/sight:• Glaucoma, cataracts, crossed eyes, detachedEars/Hearing:• Loss of hearing, deafness, infections, eustachNose/breathing:• Deviated septum, polyps, adenoiditis, sinusitiThroat/Swallowing:• Tonsillitis, strep throat, excessive snoring or stressive	nian tube dysfunction s	ctions				Yes [Not Su	No Ire
G2.	Skin Conditions/Disorders: Acne, psoriasis, keratosis Birthmarks, dermatitis, eczema, fungal infections, warts, herpes, exce Moles/pre-cancerous lesions, skin cancer, or melanoma 2nd or 3rd degree burns, scars/keloid, or revisions of cosmetic or reco	Ū					Yes [Not Su	No Ire
G3.	Musculoskeletal Conditions/Disorders: Disorders or injuries of bor as: Strain/sprain, fibromyalgia, gout Fracture, internal/external fixations, permanent hardware, amputation Arthritis, joint replacement, herniated disc, back or neck pain		tendons o	r discs	such		Yes [Not Su	No Ire
G4.	Respiratory Conditions/Disorders: Allergies, sinusitis, bronchitis, asthma, pneumonia, collapsed lung, sp Shortness of breath, chronic cough, emphysema, COPD, difficulty bre Tuberculosis, fungal infections						Yes [Not Su	No Ire
G5.	Digestive Conditions/Disorders: Infections of mouth/throat/tonsils Problems with jaw or chewing, ulcers, hernia, gastric reflux, unexplain Bypass/Banding Colitis, Crohn's Disease, Irritable Bowel Syndrome (IBS), chronic diar or hemorrhoids Diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, j	rhea, intestinal problems, colon			eeding		Yes [Not Su	No Ire
G6.	Urinary Conditions/Disorders: Bladder infections, kidney infections, stones, blood in urine Stress incontinence, urinary frequency, painful/difficult urination, cystil						Yes [Not Su	No No
G7.	Heart and Circulatory Conditions/Disorders: Anemia, bleeding/clotting disorders, Hemophilia, thrombocytopenia, V enlarged lymph nodes or lymphadenitis High blood pressure (hypertension), low blood pressure, high choleste Chest pain, angina, heart murmur, palpitations, congestive heart failur Heart attack, bypass surgery/angioplasty, valve replacement, prolapse	erol/lipids re, coronary artery disease, rhei	umatic fev	er			Yes [Not Su	
G8.	Metabolic and Endocrine Conditions/Disorders: Diabetes, Insulin Resistance, Metabolic Syndrome, Thyroid disorders Adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndro Or other immune disorder (not including the result for the HIV test)		sis				Not Su	
G9.	Brain/Nervous System Conditions/Disorders: Loss of consciousness, fainting, dizziness, numbness/tingling, weakn Confusion, memory loss, Alzheimer's, dementia, head injury, seizures Stroke, paralysis, migraine headaches or chronic severe headaches Tremors, Multiple Sclerosis, Muscular Dystrophy, Reflex Sympathetic	/epilepsy					Yes [Not Su	_ No ire

licant	's So	pcial	Secu	rity N	lumb	er	
licatio	on ID	Nun	nber				
	l I	1	ı –	1	1	l i	
				licant's Social Secu lication ID Number			licant's Social Security Number

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

G10.	Male Reproductive Conditions/Disorders:	Yes No
	a) Fertility/infertility, low sperm count, sexual dysfunction	Not Sure
	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?	☐ Yes ☐ No ☐ Not Sure
G11.	Female Reproductive Conditions/Disorders:	Yes No
	a) Pelvic pain, abnormal menstrual bleeding, endometriosis, ovarian cysts, absence of menstruation	Not Sure
	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:	🗌 Yes 🔲 No
	Menopause Birth Control Hysterectomy	Not Sure
	Other (provide reason):	
	c) Have you had an abnormal PAP smear? If "Yes," provide details on Page 17 . Date of last normal PAP smear.	🗌 Yes 🔲 No
	Date:	Not Sure
	d) Are you currently pregnant, tested positive with a home pregnancy test, or in the process of adoption or using a	🗌 Yes 🗌 No
	surrogate?	Not Sure
G12.	Nervous, Mental and Behavioral:	🗌 Yes 🔲 No
	Depression, anxiety, obsessive-compulsive or panic disorders, eating disorders, anorexia/bulimia	Not Sure
	Attention deficit, chemical imbalance, bi-polar, schizophrenia Substance abuse, counseling or support group, alcohol or chemical dependence	
G13.	Cancer/Tumors:	Yes No
615.	Cysts, tumors or abnormal growths	Not Sure
	Hodgkin's disease, leukemia or any other cancer or malignancy	
G14.	Birth Defects/Congenital Abnormalities:	🗌 Yes 🗌 No
G14.	Cerebral Palsy, Birthmarks, developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation	└── Yes └── No └── Not Sure
	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	Not Sure
	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to	Not Sure
G15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake?	Not Sure Yes No Not Sure
	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? In the past 5 years, have you ever used illegal or controlled drugs or substances, such as marijuana, cocaine,	Not Sure Yes No Not Sure Not Sure Yes No Yes No
G15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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?	Not Sure Yes No Not Sure
G15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? In the past 5 years, have you ever used illegal or controlled drugs or substances, such as marijuana, cocaine,	Not Sure Yes No Not Sure Not Sure Yes No Yes No
G15.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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?	Not Sure Yes No Not Sure Not Sure Yes No Yes No
G15. G16.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	Not Sure Yes No Not Sure Yes No Not Sure Not Sure
G15. G16.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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?	Not Sure Yes No Not Sure Not Sure Yes No Yes No
G15. G16.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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: 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.	Not Sure Yes No Not Sure Yes No Not Sure Not Sure Not Sure Yes No Not Sure
G15. G16.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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: 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.)	Not Sure Yes No Not Sure Yes No Not Sure Not Sure Not Sure Yes No Not Sure
G15. G16.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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: 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:	Not Sure Yes No Not Sure Yes No Not Sure Not Sure Not Sure Yes No Not Sure
G15. G16.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No
G15. G16. G17.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	Not Sure Yes No Yes No Yes No Not Sure Yes No Not Sure Yes No Not Sure
G15. G16. G17.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	 Not Sure Yes □ No Yes □ No Yes □ No
G15. G16. G17. G18.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure
G15. G16. G17.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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: 	 Not Sure Yes □ No Not Sure
G15. G16. G17. G18. G19.	Cerebral Palsy, Birtmarks, 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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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: 	Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure
G15. G16. G17. G18.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	Not Sure Yes No Yes No Yes No Yes No Yes No
G15. G16. G17. G18. G19. G20.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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: 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: Mare 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: Mare you been convicted of a DUI (drunk driving violation)? If "Yes," provide state(s) and date(s). Name: Mare: Mare 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)? 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 abnormal ?	Not Sure Yes No Not Sure No
G15. G16. G17. G18. G19.	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 In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? 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:	Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure Yes No Not Sure

Applicant's Social Security Number								
Application ID Number								

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

0. 110		
G22.	In the past 5 years, have you been a patient in an outpatient clinic, surgical center, urgent care, treatment center or inpatien in a hospital or other medical facility for any reason other than pregnancy?	ent Yes No
G23.	Are you a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	Yes No
G24.	Are you on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	Yes No
G25.	Have you smoked or used tobacco products, such as snuff and/or chewing tobacco, in the past 12 months? Date Stopped:	Yes No
G26.	Have you taken prescription medications or been advised to take prescription medications in the past 2 years?	Yes No
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) not already disclosed on this application ?	Yes No
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 that you have NOT seen a health care provider for ?	Yes No
NOTIO	CE: California law prohibits an HIV test from being required or used by health insurance companies as a condition insurance coverage.	n of obtaining health
NOTE	 Medical conditions that occur after the signature date and before the effective date of the coverage if approved the final underwriting decision. You shall communicate any medical condition occurring during such period. 	will be considered in
Medic	al History and Treatment History for Dependent 02	
🗌 Ch	neck here if more space is needed. Use a separate sheet of paper and staple to the back of this application.	
lf you	have answered "Yes" to any of the questions in Section G, you must provide detailed information below.	
	ion Number:	
	of Condition/Illness:	
	of Onset/Treatment (mm/yyyy): Date ended:	Still under treatment
	nent(X-ray, Labs, surgical procedure, therapy):	
	of Hospital, clinic or Health Care Provider:	
	SS:	
	State: ZIP:	
Teleph	none Number: ()	
Quest	ion Number:	
Name	of Condition/Illness:	
Date of	of Onset/Treatment (mm/yyyy): Date ended:	Still under treatment
Treatn	nent(X-ray, Labs, surgical procedure, therapy):	
Name	of Hospital, clinic or Health Care Provider:	
Addre	SS:	
	State: ZIP:	
Teleph	none Number: ()	
	ion Number:	
	of Condition/Illness:	
		Still under treatment
	nent(X-ray, Labs, surgical procedure, therapy):	-
	of Hospital, clinic or Health Care Provider:	
City	ss: State: ZIP:	
reiebt	none Number: ()	

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/IIIness:
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"
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

	Applicant's Social Security Number
	Application ID Number
H. Effective Date (Requesting an effective date DOES NOT GUARANTEE under	
If Aetna approves my application, I am requesting an effective date of the 1st or the If your requested effective date is prior to your application approval date, Aetna	
I. Statement of Enrollment Conditions	
Each member of the family will be medically underwritten separately and assigned a	
If one or more family members are not approved, Aetna will cover the approved famil I, the applicant, instruct Aetna not to cover any eligible family members unless a	
I prefer to receive written communication regarding my application via email.	
J. PAYMENT OPTIONS – Please select the method of payment for your initial a	pplication and subsequent premium payments.
Initial Payment	
 Easy Pay (complete the EFT information below) Credit Card (complete the credit card information below) 	
Recurring or subsequent Payment	
Easy Pay (complete the EFT information below)Bill me monthly	
Easy Pay (Electronic Fund Transfer - EFT)	
Checking Account Number:	0000
	Sut.
Name of Bank:	But the State
	JANE C. DOE
Name(s) on Checking Account:	50-122 21660 OKNARD 5T WOODLAND HILS, CA 91367

Terms of Agreement: My account(s) at the institution named has sufficient funds to pay	
charge, or credit entries to pay premiums/charges for authorized policies, and the entries receives full and final credit for the payment. I understand that corrections to the entries payment of Aetna's premium will be debited/charged on or after the premium due of application signature on Page 22, Section P, I am accepting the terms of the Easy Pay A Any rate adjustment made in accordance with the underwriting process will be auto application. Please be advised that such rate adjustment may result in an increase NOTE: Aetna reserves the right to refuse/terminate electronic payment services a terminates it. Joint accounts require the signature of ALL account authorized period.	are my transaction receipt. There is no payment to Aetna until Aetna may involve an account adjustment, and that my direct electronic ate. I understand that by electing "Easy Pay" above and with my greement. omatically charged to your account upon approval of your of <u>0% to 100% of the standard premium</u> . t any time. This agreement remains in effect until Aetna/member
Credit Card Payment Option	
Credit Card Type Cardholder's Name (exactly as it appears o	n the card)
	Card Expiration Date
Credit card payment is for your <u>initial premium payment only</u> and will be charged u	pon approval of your application. You must elect EFT or monthly
billing for your next premium payment.	
Any rate adjustment made in accordance with the underwriting process will be automatic adjustment may result in an increase of 0% to 100% of the standard premium .	ally charged to your account. Please be advised that such rate
aujuounent may recurt in an moreage of vit to revie of the standard premidili.	

				Applicant's Social Security Number
				Application ID Number
K. Statement of Acc	ountability - To k	be completed if the applicant cannot	ot complete the application	on.
1			esentation of the applicant	
· ·	., .	nally read this form to the applicant a		
		ent command of the English language d and unable to complete this applica		n
—	0, 1	contents of this application.		
If translated, I also ful	ly explained the "	Conditions and Agreement" under Se	ction O to the applicant.	
Signature of Represe	ntative (Required):		Today's Date <i>(Required)</i> :
City, Zip Code, State:			Pr	none Number:
L. Insurance Produce	cer Attestation -	To be completed by Insurance Pro	ducer/General Agent	
		t (and spouse/domestic partner, if ap	plying) at the time this	General Agent Insurance Broker
application was e If "No," please ex				Yes No Yes No
	pian.			
2. To the best of you	ur knowledge, is t	he information on this application con	nplete and accurate?	Yes No Yes No
If "No," please ex				
		Alter a large to be the	- La Hard - La Persona - La Sana - La Persona - La Sana - La	
		rial fact you know to be false, you ilable under current law, be subjec		to
\$10,000.		mable ander barrent law, be bubjet	to a own penalty of up	
		erstand English (or via translation wh		the Yes No Yes No
		formation on this application, and that	at the applicant fully	
understands you Signature of Insurar		auirod)	Signature of Conoral A	gent (Required, if applicable)
Signature of insular		quileu)	Signature of General A	gent (Required, il applicable)
Date	E-mail Address		Date	E-mail Address
Name of Insurance P	roducer or Agency	v to be assigned as Broker of Record	Name of General Agent (print name)
(print name)				
TIN Insurance Produc	cer or Agency to b	e assigned as Broker of Record	Agent TIN Number	
Streat Address (Suite	No /Demonal Ma	il Dov (DMD) No (City/State/ZID	Street Address (Suite No	./Personal Mail Box (PMB) No./City/State/ZIP
Code)	NO./Personal Ma	il Box (PMB) No./City/State/ZIP	Code)	
,			,	
Telephone Number		Fax Number	Telephone Number	Fax Number
()		()	()	()
M. Aetna Sales Rep	resentative			

Last Name of Sales Representative (print name)	First Name of Sales Representative (print name)
Mattozzi	Marcia

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.
- 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.

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

Q. Contact Information

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

Aetna Advantage Plans		
PO Box 14381	Fax #: 866-892-8396	
Lexington, KY, 40512-4381	www.aetna.com/members/individuals	
U <i>i i i i i i i i i i</i>		

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.

<u>Planes basados en DMO y HMO</u> - **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						
			I	1		

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 Լեզվական Ծառայություններ։ Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով։ Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-877-287-0117 համարով։ Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի 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 مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی بر ایتان خوانده شوند. بر ای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 0117-287-1871 تماس بگیرید. بر ای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 4357-432-800-1 تلفن کنید. Persian

ਮੁਫ਼ਤ 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 'ਤ ਸਾਨ ਫ਼ਨ ਕਰੋ। ਵਧੇਰ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੇਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੇਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្ងៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមាន

បង្ហាញលើប័ណ្ណសំពាល់ខ្លួនរបស់អ្នក ឬលេខ 1-877-287-0117 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា

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 1100-287-287 . للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 4357-292-800-170-201

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

CDI Notice of Language Assistance-Trad

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