aetna®

Connecticut – Application for Aetna Individual Health Insurance*

Aetna Life Insurance Company

Primary Applicant's Name

Applicant's Social Security Number

INSTRUCTIONS:

- **Please complete in blue or black ink only. PRINT clearly.**
- **The information you provide is confidential.**
- **All answers must be true, complete and truthful.**
- **Intentional misrepresentation may result in the policy being modified or terminated.**
- **Applications for coverage must be submitted during.**
  - **<u>Annual Open Enrollment Period</u> – October 1, 2013 through March 31, 2014**
    If applying during this period, check the box in Section C below.
  - **<u>Special Enrollment Periods</u> – If applying outside of Annual Open Enrollment Period see Section D.**

Section A – Primary Applicant Information

Primary Applicant Last Name	First Name	Middle Initial
Home Address (No PO Boxes)		Apt. Number
City	State	ZIP Code
Mailing Address (If different from your Home address)		
City	State	ZIP Code
County	E-mail Address	
Telephone Number **Primary** (_____)_____ **Secondary** (_____)_____	If we need to call you with any question about your application, when is the best time to reach you? ☐ Morning ☐ Afternoon ☐ Evening	

Section B – Coverage Information

Application Type (Select one):

☐ New medical coverage ☐ Add dependent(s) to current coverage

☐ Change current coverage ☐ Add dental coverage

Requested Effective Date

_____ **(1st or 15th of the month). (Aetna will assign the effective date once your application has been processed.)**

Section C – Annual Open Enrollment Period

☐ Application submitted between **October 1, 2013** and **March 31, 2014**

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

Primary Applicant's Name

Section D – Special Enrollment Period

If you are applying outside of the Annual Open Enrollment Period and one of the events listed below applies to you, check the appropriate box. The Special Open Enrollment Period begins on the date of the event checked and continues for 60 days.

Date of Event	Event
_____	☐ Loss of employer coverage due to termination of employment, reduction in hours, or coverage no longer offered to my employment class.
_____	☐ Loss of employer or individual coverage because no longer eligible as a dependent.
_____	☐ Loss of employer or individual coverage because of divorce from policyholder, death of policyholder, or policyholder eligible for Medicare.
_____	☐ Loss of Medicaid or CHIP coverage.
_____	☐ Coverage needed for new dependent through marriage, birth, adoption or placement for adoption.
_____	☐ Coverage needed following loss of eligibility for Exchange subsidies.
_____	☐ Other, please explain. _____

If you have been enrolled in a plan that renews during 2014, you may apply during the 30-day period prior to your renewal date. If this applies, provide renewal date below:

☐ Date of renewal. _____

Section E – Coverage Selection

Choose the plan that best meets your needs.

Catastrophic:	Bronze:	Silver:
☐ **Aetna Basic PD**	☐ **Aetna Advantage 5750 PD**	☐ **Aetna Classic 3500 PD**
	☐ **Aetna Advantage 6350 PD**	☐ **Aetna Classic 5000 PD**
	☐ **Aetna AdvantagePlus 5500 PD**	

Dental: ☐ **DMO** ☐ **PPO**

Section F – Persons Requesting Coverage

List all family members you wish to be covered under this policy.

Dependent children are eligible 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.

If any person has regularly used tobacco products (cigarettes, pipe, cigars, snuff, or chewing tobacco) within the last 6 months, check Yes as Tobacco User below. Regular use means an average of four or more times per week. If choosing an HMO product for Medical (M) or DMO for Dental (D), enter the primary care MD or Dentist office ID Number.

Primary Applicant Name (Last, First, Middle Initial)				Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No	If choosing HMO/DMO include Primary Office ID Number ☐ M Primary Office ID Number _____ ☐ D Primary Office ID Number _____
Spouse/Domestic Partner Name (Last, First, Middle Initial)				Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No	If choosing HMO/DMO include Primary Office ID Number ☐ M Primary Office ID Number _____ ☐ D Primary Office ID Number _____
Child 1 Name (Last, First, Middle Initial)				Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No	If choosing HMO/DMO include Primary Office ID Number ☐ M Primary Office ID Number _____ ☐ D Primary Office ID Number _____
Child 2 Name (Last, First, Middle Initial)				Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No	If choosing HMO/DMO include Primary Office ID Number ☐ M Primary Office ID Number _____ ☐ D Primary Office ID Number _____

continued

Primary Applicant's Name

Section F – Persons Requesting Coverage (Continued)

To be completed by the primary Applicant

Marital Status ☐ Married ☐ Domestic Partner ☐ Single	Are you a resident of the state in which you are applying? ☐ Yes ☐ No
If you are currently covered by accident and sickness insurance, is this plan intended to replace your current coverage? ☐ Yes ☐ No	
How would you like Aetna to communicate with you regarding your application and coverage? ☐ E-mail ☐ Mail	Would you like to receive emails from us regarding your benefits, programs and general health information? ☐ Yes ☐ No

Would you like to turn off paper? ☐ Yes ☐ No

If you turn off paper, we will send you emails about your claims and other activity on your account. You can also view your statements and communications online.

Please note that there may be state or federal regulations that prohibit us from communicating with you in your preferred method in some instances.

Are you a Native American Indian? ☐ Yes ☐ No

Are you a Citizen of the United States? ☐ Yes ☐ No

If "No," provide most recent date of arrival in the U.S.: _____ INS ID Number: _____

Are the other applicants being added to this application Citizens of United States? ☐ Yes ☐ No

If "No," provide Name, most recent date of arrival in the U.S. and INS ID Number.

Name	Most recent arrival date	INS ID Number

Do you read and write English? ☐ Yes ☐ No (If No, the Statement of Accountability must be completed.)

If "No," Primary Spoken Language: _____ Primary Written Language: _____

Did you complete this application? ☐ Yes ☐ No (If No, the Statement of Accountability must be completed.)

Statement of Accountability – Must be completed if the applicant answered "No" to read or write English or the applicant did not complete this application.

I _____, acting as (describe your relationship) _____ have personally read this form to the applicant and completed the application because:

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

☐ Applicant is legally incapacitated and unable to complete this application

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

_____

If translated, I also fully explained to the applicant the "Authorization to Disclose Personal Health Information" and "Signature(s) Required" under **Sections G and J**.

Signature of Representative ***(Required)***	Today's Date ***(Required)***

Print Name

Street Address

City	State	ZIP Code	Telephone Number ( )

Primary Applicant's Name

Section G – Authorization to Use and Disclose Protected Health Information

Purpose of this Authorization Form
By signing this form, I authorize Aetna, or Aetna's representatives, to receive and use Protected Health Information (PHI) (e.g., hospital records, physician records, claims or benefit records or lab results) a) to verify tobacco use, b) to coordinate medical care and case management, and/or c) to determine future premium rates for Aetna's individual insurance line of business. For this purpose, I authorize Aetna to disclose my PHI to other persons or organizations performing services on Aetna's behalf.

I further authorize any licensed physician, medical practitioner, health care provider, hospital, clinic or other medical or medically related facility, insurance or reinsuring company, or other organization, institution, or person that has any record or knowledge of my health to disclose such information to Aetna to the extent permitted by law.

I understand that my PHI may be used by, or disclosed to or by, organizations and persons who are subject to federal or state privacy laws.

Term of Authorization
I agree this Authorization shall be valid for eighteen (18) months from the signature date below.

Right to Revoke
I understand I may revoke this authorization at any time by giving advance written notice to Aetna. If this application was completed on a computer, I acknowledge that I have not actually signed this application but instead authorize Aetna to print "Electronic Signature" on this form.

I have read and considered the contents of this form.

Primary Applicant's or Parent/Guardian's Signature	Date
Spouse / Domestic Partner's Signature	Date
Dependent's signature (age 18 or older)	Date
Dependent's signature (age 18 or older)	Date

Primary Applicant's Name

Section H – Payment Options (Select the method of payment for your initial application and following premium payments.)

Initial Payment

- ☐ Easy Pay – Electronic Check (complete the EFT information below)
- ☐ Credit Card (complete the credit card information below)

Recurring or Follow Up Payments

- ☐ Easy Pay (complete the EFT information below)
- ☐ Check or Money Order

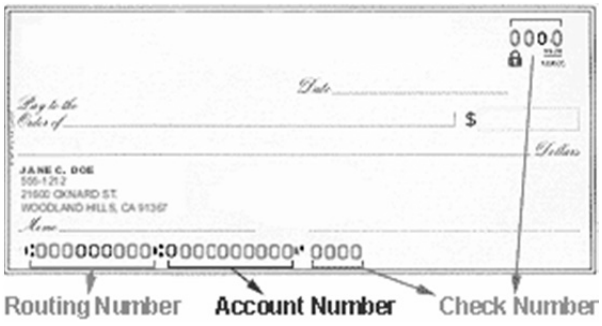
Easy Pay (Electronic Fund Transfer – EFT)

Checking Account Number: _____

Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Bank: _____

Name(s) on Checking Account: _____



Terms of Agreement: My account(s) at the institution named has sufficient funds to pay all debits and charge credits. Aetna shall initiate electronic debit, charge, or credit entries to pay premiums/charges for authorized policies, and the entries are my transaction receipt. There is no payment to Aetna until Aetna receives full and final credit for the payment. I understand that corrections to the entries may involve an account adjustment, and that **my direct electronic payment of Aetna's premium will be debited/charged on or after the premium due date.** I understand that by electing the Easy Pay box above and with my application signature in **Section J**, I am accepting the terms of the Easy Pay Agreement.

Any rate adjustment made in accordance with the enrollment process will be automatically charged to your account upon approval of your application *prior to the effective date*. Please be advised that tobacco use may result in an increase to the standard premium.

NOTE: Aetna reserves the right to refuse/terminate electronic payment services at any time. This agreement remains in effect until Aetna/member terminates it. Joint accounts require the signature of ALL account authorized persons (**Section J**) even if not applying.

Credit Card Payment Option

Credit Card Type ☐ Visa ☐ MasterCard	Cardholder's Name (exactly as it appears on the card)
Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	Card Expiration Date

Credit card payment is for your initial premium payment only and will be charged upon approval of your application *prior to the effective date*. You must elect EFT or monthly billing (check or money order) for your next premium payment.

Any rate adjustment made in accordance with the enrollment process will be automatically charged to your account. **Please be advised that tobacco use may result in an increase to the standard premium.**

Primary Applicant's Name

Section I – Case Management (OPTIONAL – This information will be used to help coordinate your care. It will not impact your premium rate or eligibility for coverage.)

Check all boxes that apply.

☐ AIDS	☐ Defibrillator /AICD	☐ Paralysis
☐ ALS (Lou Gehrig's Disease)	☐ Dialysis	☐ Paraplegic
☐ Auto Immune Disease	☐ End of Life/Hospice	☐ Pregnancy – high risk or multiple births
☐ Cerebral Palsy	☐ Hemodialysis	☐ Prosthesis present
☐ Chronic Pain	☐ Morbid Obesity (BMI > 42)	☐ Quadriplegic
☐ Clotting Disorder	☐ Multiple Sclerosis	☐ Surgery scheduled or pending
☐ Congestive Heart Failure	☐ Muscular Dystrophy	☐ Traumatic Brain Injury
☐ COPD using oxygen	☐ Myasthenia Gravis	☐ Other: _____

Name of Applicant	**Condition(s)**

Section J – Signature(s) Required – **All Applicants (Primary/Spouse and dependents) age 18 and older must read and sign this form below.**

By signing this form you agree to the following:

1. The answers in this application are true and complete to the best of my knowledge and belief.
2. The children listed on this application are my legal dependents.
3. I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by Aetna, and may face legal liability, including legal action based on fraud.
4. I have read this entire application, or it has been read to me.
5. The information I have provided in this application will be used by Aetna to determine whether to issue coverage and the premium amount for such coverage.
6. No coverage shall be in force until Aetna processes this application and Aetna has notified me of my effective date.
7. This application will become part of the contract between me and Aetna.
8. I or my legal representative has the right to receive a copy of this application upon request. I agree that a photocopy shall be as valid as the original. A legal facsimile signature shall have the same force and effect as the original.
9. I authorize Aetna to electronically transmit the information contained in this application.
10. If I purchase dental coverage, a dependent child who turns 19 years old and is no longer eligible for pediatric dental coverage will automatically be enrolled in the dental plan, but I retain the right to reverse that enrollment.

Primary Applicant's or Parent/Guardian's Signature	Date
Spouse / Domestic Partner's Signature	Date
Dependent's signature (age 18 or older)	Date
Dependent's signature (age 18 or older)	Date

Primary Applicant's Name

Section K – Insurance Producer or Agent (Required If Applicable)

Complete if Broker of Record is an Individual Producer (not an Agency)

Print Name of Producer	NPN of Agent
Signature of Producer (required if applicable)	Telephone Number ( )
E-mail Address	Fax Number ( )
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)	

Complete if Broker of Record is an Agency

Name of Agency **Victorson Associates, Inc.**	TIN of Agency **11-2157267**	
E-mail Address **vainc@victorson.com**	Telephone Number (**631**) **265-7456**	Fax Number (**631**) **265-7054**
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code) **321 East Main St., Suite 6, Smithtown, NY 11787**		
Print Name of Producer Representing Agency **Gary Victorson**	NPN Number **3288682**	
Signature of Agency Representative (required if applicable)		

General Agent

Print Name of General Agent	TIN of General Agent
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)	

Aetna Sales Representative

Last Name of Agent (Print Name)	First Name of Agent (Print Name)	License Number

Section L – Contact Information

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

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

Fax #: 866-892-8396

Website for information: www.aetna.com/members/individual