



# Aetna Individual Advantage (SM) for Individuals and Families

**Instructions:**

- Enrollment form must be completed by the subscriber in blue or black ink. **Please PRINT clearly. (A photocopy of this enrollment form will not be accepted.)**
- Enrollment form must be completed in its entirety and one (1) form of payment selected or processing time will be delayed.
- Signature and date is required.

**[ Send completed enrollment form to:**  
 Aetna Advantage Dental Plans, U22N  
 P.O. Box 730  
 Blue Bell, PA 19422  
**Fax Form to:**  
 Individual billing and Enrollment 1-860-975-1620 ]

**A. Subscriber Information**

Last Name (Last, First, Middle Initial)		First Name		Middle Initial	
Address		City		State	ZIP Code
Home Telephone Number (Include Area Code)		Cell Phone Number (Include Area Code)		E-Mail Address (Optional)	

**B. [ Election of Dental Coverage**

Aetna Individual Advantage Dental PPO Plan       Aetna Individual Advantage Dental PPO Plus Plan ]

**C. Individuals Covered (Complete this section if you are enrolling your spouse and/or family member(s). You may enroll any or all eligible family members.)**

Family Code*	Last Name	First Name	M.I.	Social Security Number	Date of Birth (MM/DD/YYYY)
APP					
SP					
DEP 1					
DEP 2					
DEP 3					

**D. Effective Date**

If Aetna approves my enrollment form, I am requesting an effective date beginning the 1<sup>st</sup> of the \_\_\_\_\_ (month).

**E. Signature**

Applicant's Signature	Date
-----------------------	------

**PAYMENT OPTIONS****F. Easy Pay (By selecting this option you are approving the automatic withdrawal of your initial premium and all subsequent premium payments.)**

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

Checking Account Number: \_\_\_\_\_

Routing Number:

Name of Bank: \_\_\_\_\_

Name(s) on Checking Account: \_\_\_\_\_



**No**, I do not want to use Easy Pay. Please bill me each month.

**Terms of Agreement:** My account(s) at the institution named has sufficient funds to pay all debits and charge credits. Aetna shall initiate electronic debit, charge, or credit entries to pay premiums/charges for authorized policies, and the entries are my transaction receipt. There is no payment to Aetna until Aetna receives full and final credit for the payment. I understand that corrections to the entries may involve an account adjustment, and that **my direct electronic payment of Aetna's premium will be debited/charged on or after the premium due date each month. No bill will be issued.** I understand that by checking the "Yes" box above and with my enrollment form signature on **Page 1, Section E**, I am accepting the terms of the Easy Pay Agreement.

**Any rate adjustment made in accordance with the underwriting process will be automatically charged to your account.**

**NOTE: The initial premium payment will be deducted upon approval of your enrollment form.** Aetna reserves the right to refuse/terminate electronic payment services at any time. This agreement remains in effect until Aetna/member terminates it. Joint accounts require the signature of ALL account authorized persons (**Page 1, Section E**) even if not applying.

**PAYMENT OPTIONS (continued)****G. Credit Card Payment Option**

Credit Card Type <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard		Cardholder's Name (exactly as it appears on the card)		
Account Number □ □ □ □ - □ □ □ □ - □ □ □ □ □ □ □ □		Card Expiration Date	Card Verification Code* □ □ □	
<p><b>Credit card payment is for your initial premium payment only and will be charged upon approval of your enrollment form. You will receive a bill on your next billing statement.</b></p> <p>Any rate adjustment made in accordance with the underwriting process will be automatically charged to your account.</p> <p>*The Verification Code can be found on the back of your credit card. This 3-digit code is usually the last three digits located in the signature panel.</p>				

**H. Payment by Personal Check or Money Order**

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

**I. Insurance Producer Information (Please complete the information below in full)**

1. Are you aware of any information not disclosed on this enrollment form relating to the health, habits or reputation of any person listed on this enrollment form which might have a bearing on the risk? If "Yes," please attach explanation.		<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Did you see the proposed applicant at the time this application was executed? If you answered "No" to either question above, please explain:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Signature of Insurance Broker <i>(Required if sold by an agent/broker)</i>		Name of General Agent <i>(print name)</i>	
Date	E-mail Address	E-mail Address	
Name of Insurance Broker <i>(print name)</i>		General Agent TIN Number	
TIN of Broker or Agency		Address <i>(Street, Suite #, POB, City, State, ZIP Code)</i>	
Address <i>(Street, Suite #, POB, City, State, ZIP Code)</i>		Telephone Number (    )	
Telephone Number (    )	Fax Number (    )	Fax Number (    )	

**J. Aetna Sales Representative (if applicable)**

Last Name of Sales Representative <i>(print name)</i>	First Name of Sales Representative <i>(print name)</i>
---	--

**K. Authorization**

<p>I have read the information contain in this application and choose to enroll. I understand that my enrollment is subject to receipt of payment and verification of funds. Eligibility will begin on the first day of the month following receipt of the enrollment form. I understand that the Electronic Funds Transfer (EFT) for the monthly premium payment will be automatically deducted from my bank account.</p> <p>I hereby certify that the information contained in this application is true and complete.</p>	
Applicant's Signature	Date