### Thank you for choosing...



# **Enrolling is Simple. Just Follow These 3 Easy Steps...**

## Step 1

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. Please make sure to sign and date the application where applicable. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact your agent at: (630) 930-9364.

## Step 2

**SELECT THE TYPE OF BILLING YOU WANT** – monthly (by using Easy Pay to deduct the monthly premium from a checking account).

If you do not want to use the convenience of Easy Pay, you can choose to have your bill be mailed to you each month, but you most use a credit card in section G for your initial payment. Subsequent bills will be sent to your house and will not be charged to your card.

# Step 3

#### **FAX THE COMPLETED APPLICATION TO:**

Fax: (847) 847-220-9280

We will be in contact with you upon receipt of your completed application. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.



# **FAX COVER LETTER**

(Please ignore this form if you do not have access to a fax machine.)

\*\*Please FAX this cover letter with the completed application to:

FAX#: (847) 220-9280

Please accept my completed application for submittal and contact me to confirm receipt of	this application
Name	
E-mail	-
Date	
Time	
☐ Please contact me at this phone number after you have reviewed my applic completeness and accuracy	
☐ Please contact me at this email after you have reviewed my application for completeness and accuracy	



# 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 Initi	Middle Initial		
Address		City		State	ZIP Code			
Home Telephone Number (Include Area Code)	er (Include Area Code) E-Wail Address (Optional)							
B. [Election of Dental Coverage	•			•				
Aetna Individual Advantage Dental PF	PO Plan 🗌 Aetna	a Individual Advanta	ge Dental PPO Plu	s Plan ]				
C. Individuals Covered (Complete this section	n if you are enrolling yo	our spouse and/or fa	mily member(s). Yo	u may en				
Family     Code*   Last Name		First Name M		M.I.	Social Sec Number	urity	ity Date of Birth (MWDD/YYYY)	
APP								
SP								
DEP 1								
DEP 2								
DEP 3								
D. Effective Date		1		<b>I</b>			•	
If Aetna approves my enrollment form, I am re  E. Signature  Applicant's Signature	aquesting an enective o	aate beginning trie	~ OI tile	(monti	11).		Date	
PAYMENT OPTIONS  F. Easy Pay (By selecting this option you are	approving the automati	c withdrawal of your	initial premium and	l all subse	equent premi	um payme	ents.)	
Yes, I would like to use Easy Pay.							0000	
Checking Account Number:					Nate		<b>6</b>   1000	
Routing Number:			Bay to the Crites of				\$ Geller	
Name of Bank:			JANE C. DOE 505-1212 21500 OKNARD ST.					
Name(s) on Checking Account:			WOODLAND HILLS, CA 913	er .	landa and a second			
			:000000000	:000000	0000 0000	1		
☐ <b>No</b> , I do not want to use Easy Pay. Plea	se bill me each month.		Routing Numb	er Ar	count Num	her	heck Number	
Terms of Agreement: My account(s) at the	institution named has s	sufficient funds to pa						
charge, or credit entries to pay premiums/cha Aetna receives full and final credit for the pay electronic payment of Aetna's premium wi that by checking the "Yes" box above and wit	rges for authorized pol ment. I understand tha II be debited/charged	licies, and the entrie at corrections to the <b>I on or after the pr</b> e	s are my transactio entries may involve emium due date ea	n receipt e an acco a <b>ch mon</b>	. There is no ount adjustme th. <b>No bill w</b>	payment ent, and th <b>ill be iss</b> i	t to Aetna until nat <b>my direct</b> <b>ued</b> . I understand	
Any rate adjustment made in accordance	with the underwriting	process will be au	tomatically charg	ed to yo	ur 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								
payment services at any time. This agaccount authorized persons ( <b>Page 1</b> ,	-		nber terminates it.	Joint acc	ounts require	e the signa	ature of ALL	

#### PAYMENT OPTIONS (continued) G. Credit Card Payment Option Credit Card Type Cardholder's Name (exactly as it appears on the card) MasterCard Visa Account Number Card Expiration Date Card Verification Code\* 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. Any rate adjustment made in accordance with the underwriting process will be automatically charged to your account. \*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. 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. 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. ∏Yes ∏ No ∏Yes ∏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: Signature of Insurance Broker (Required if sold by an agent/broker) Name of General Agent (print name) Date E-mail Address E-mail Address Name of Insurance Broker (print name) General Agent TIN Number TIN of Broker or Agency Address (Street, Suite #, POB, City, State, ZIP Code) Address (Street, Suite #, POB, City, State, ZIP Code) Telephone Number Telephone Number Fax Number Fax Number J. Aetna Sales Representative (if applicable) Last Name of Sales Representative (print name) First Name of Sales Representative (print name) K. Authorization

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.

I hereby certify that the information contained in this application is true and complete.

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Applicant's S	ignature			Date
1				

GR-68453 (1-08) **2**