Thank you for choosing...



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

# <u>Step 1</u>

**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 Init	ial
Address		City		State	ZIP Code
Home Telephone Number (Include Area Code) Cell Phone Number		r (Include Area Code)	E-Mail Add	ress (Option	al)

#### 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	MI.	Social Security Number	Date of Birth (MIWDD/YYYY)
APP					
SP					
DEP 1					
DEP 2					
DEP 3					

#### D. Effective Date

III Aeuna approves my enroiiment iorm, i am requesting an effective date beginning the 1∞ of the (mon	If Aetna approves m	v enrollment form,	am requesting an effective date beginning the 1st of the	(month
---	---------------------	--------------------	--	--------

Date

### E. Signature

Applicant's Signature
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#### 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.		0000		
Checking Account Number:	Test	<b>a</b>		
Routing Number:	Page to the Poles of	Tellers		
Name of Bank:	JANE C. DOE 500-1212	- Setters		
Name(s) on Checking Account:				
	0000 0000000000000000000000000000000000			
No, I do not want to use Easy Pay. Please bill me each month. Routing Number Account Number Check Number				
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				

Aetha 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 Aetha'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.

R-POD

## PAYMENT OPTIONS (continued)

G. Credit Card Payment Option						
Credit Card Type	Cardholder's Name (exactly as i	t appears on the card)				
Visa MasterCard						
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 or your next billing statement.						
Any rate adjustment made in accord	lance with the underwriting process will be	automatically charged to your account.				
*The Verification Code can be found	I on the back of your credit card. This 3-di	git 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 r	money order made payable to "Aetna" and	l attach to your completed enrollment form.				
I. Insurance Producer Information	ו (Please complete the information below ir	n full)				
	1. Are you aware of any information not disclosed on this enrollment form relating to the health, habits or reputation of any					
	form which might have a bearing on the ris					
<ol> <li>Did you see the proposed applicant at the time this application was executed?</li> <li>If you answered "No" to either question above, please explain:</li> </ol>						
Signature of Insurance Broker (Required if	sold by an agent/broker)	Name of General Agent (print name)				
Date E-mail A	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 nar	ne)	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.

Applicant's Signature