aetna®

Illinois 2016
Application for Aetna Individual Health Insurance

Aetna Life Insurance Company and Aetna Health Inc.

Primary Applicant's Name

Applicant's Social Security Number

INSTRUCTIONS:

- **Complete in blue or black ink only.**
- **PRINT clearly.**
- **All answers must be complete and truthful.**

IMPORTANT NOTES:

- **The information you provide is confidential.**
- **Intentional misrepresentation may result in the policy being modified or terminated.**
- **Proof of state residency may be required**

Section A – Primary Applicant Information (for parent/guardian for Child-Only application)

Primary Applicant Last Name	First Name	Middle Initial
Home Address (No PO Boxes)		Apt. Number

City	State	ZIP Code	County

Relationship (If Child-Only Application)

Mailing Address (If different from your Home address)		
City	State	ZIP Code

E-mail Address

Telephone Number	If we need to call you with questions about your application, when is the best time to reach you?
Primary (_____) _____ **Secondary** (_____) _____	☐ Morning ☐ Afternoon ☐ Evening

Section B – Application Type

Application Type (Select one):

☐ New medical coverage ☐ Child-Only Application (Children up to age 21) ☐ Add dental coverage
☐ Change current coverage ☐ Add dependent(s) to current coverage

Your Effective Date will be assigned by Aetna, based on the receipt date of your application.

Primary Applicant's Name

Section C – Enrollment Period

☐ **Annual Open Enrollment Period** (Annual period to enroll in medical coverage if no Special Enrollment Period applies. If you qualify for a Special Enrollment Period during the Annual Open Enrollment Period, coverage may start sooner.)

☐ **Special Enrollment Period** (If you qualify for a Special Enrollment Period, you can enroll in medical coverage outside the Annual Open Enrollment Period. If you qualify for a Special Enrollment Period during the Annual Open Enrollment Period, coverage may start sooner.)

If one of the events listed below applies to you, check the appropriate box.

The Special Open Enrollment Period for the following events begins 60 days prior to the date of the event checked and continues for 60 days after.

Date of Event	Event
_____	☐ Loss of employer coverage due to termination of employment, reduction in hours, coverage no longer offered to my employment class, or expiration of COBRA coverage.
_____	☐ 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 enrolled in Medicare.
_____	☐ Loss of Medicaid or CHIP coverage.
_____	☐ Coverage needed following loss of eligibility for Exchange subsidies.
_____	☐ A permanent move.

The Special Open Enrollment Period for the following events begins on the date of the event checked and continues for 60 days.

_____	☐ Coverage needed for new dependent through marriage.
_____	☐ Coverage needed for new dependent through birth, adoption or placement for adoption.
_____	☐ Other, please explain. _____

Section D – Coverage Selection

Choose the plan that best meets your needs.		
Bronze:	**Silver:**	**Gold:**
Open Access Managed Choice (OAMC)		
☐ **Aetna Bronze $15 Copay Savings Plus OAMC PD**	☐ **Aetna Silver $10 Copay Savings Plus OAMC PD**	☐ **Aetna Gold $10 Copay Savings Plus OAMC PD]**
☐ **Aetna Bronze Deductible Only HSA Eligible Savings Plus OAMC PD**		
Aetna Whole Health (HMO)		
☐ **Aetna Whole Health Chicago Bronze $15 Copay PD**	☐ **Aetna Whole Health Chicago Silver $10 Copay PD**	☐ **Aetna Whole Health Chicago Gold $10 Copay PD**
☐ **Aetna Whole Health Chicago Bronze Deductible Only HSA Eligible PD**		
Is the issuance of this coverage replacing your existing coverage? ☐ Yes ☐ No		

Primary Applicant's Name

Section E – Persons Requesting Coverage

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

Dependent children are eligible up to age 26 (Military Veterans up to age 30).

For a Child-Only application, start listing children at Child 1, with the youngest child listed first.

☐ Check here if you need more space 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 six (6) months, check "Yes" as Tobacco User below (This does not apply to applicants under the age of 18). Regular use means an average of four or more times per week.

If any person uses tobacco for religious or ceremonial purposes only, check "No" for Tobacco User below.

If choosing an HMO product for Medical (M), enter the primary care MD 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 include Primary Office ID Number ☐ M 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 include Primary Office ID Number ☐ M 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 include Primary Office ID Number ☐ M 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 include Primary Office ID Number ☐ M Primary Office ID Number _____
Child 3 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 include Primary Office ID Number ☐ M Primary Office ID Number _____

continued

Primary Applicant's Name

Section E – 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
How would you like Aetna to communicate with you regarding your application and coverage? ☐ E-mail ☐ Mail	Would you like to receive e-mails 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 e-mails 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.

Are any applicants enrolled in or entitled to Medicare benefits? ☐ Yes ☐ No

If Yes, provide name(s) of these applicants: _____

Are all applicants listed on this application Citizens of the United States? ☐ Yes ☐ No

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

Proof of legal residency will be required.

Name	Most recent arrival date

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

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

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

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 F and H**.

Signature of Representative ***(Required)***	Today's Date ***(Required)***
Print Name	
Street Address	

City	State	ZIP Code	Telephone Number ( )

Primary Applicant's Name

Section F – Authorization to Use and Disclose Protected Health Information

Please read the following carefully before completing your authorization. You may refuse to sign this authorization.

Purposes of this Authorization Form
By signing this form, I authorize Aetna, or Aetna's representatives, to request, receive and use Protected Health Information (PHI), including but not limited to, prescribed medication history or other pharmaceutical information, hospital records, physician records, claims or benefit records or lab results for the following purposes: a) to verify tobacco use, b) to coordinate medical care and case management, and/or c) for risk adjustment activities. I authorize Aetna to disclose my PHI for the purposes stated above to other persons or organizations performing services on Aetna's behalf.

I further authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, lab, pharmacy, pharmacy benefit manager 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 Aetna may pay a fee to a third party to collect my health information. The health information released to Aetna may be related to chronic diseases, mental illness, alcohol or substance abuse, Human Immunodeficiency Virus (HIV) infection, or Acquired Immune Deficiency Syndrome (AIDS).

Aetna may not condition your treatment, payment, enrollment or eligibility for benefits, on whether or not you sign this authorization.

Health information received by Aetna will not be re-disclosed without your authorization unless permitted by law, as described in Aetna's Notice of Privacy Practices. Information that is re-disclosed may not be protected under federal 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 that I may revoke this authorization at any time by giving written notice to Aetna using the address provided in Section J. My revocation will not have any effect on actions Aetna has already taken before receiving my notice.

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 G – 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)

☐ Monthly Billing Statement

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 H**, 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 H**) 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 H – 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. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance 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 Aetna and me.
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.

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 I – 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 **Illinois Health Agents Inc.**	TIN of Agency **27-0622041**	
E-mail Address **ryan@ilhealthagents.com**	Telephone Number (**312**) **588-9915**	Fax Number (**847**) **220-9280**
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code) **75 Forest Ave. Glen Ellyn, IL 60137**		
Print Name of Producer Representing Agency **Ryan Kennelly**	NPN Number **8478911**	
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 J – 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: http://www.aetna.com/individuals-families.html