



Aetna Advantage Plans for Individuals and Families - HMO* and PPO** - PA

Subscriber's Social Security Number

Instructions:

- Enrollment form must be completed by the subscriber in blue or black ink. **(A photocopy of this application will not be accepted.)**
- This enrollment form must be completed in its entirety and first month's premium check payable to Aetna enclosed or processing time will be delayed.**

- Signature and date is required on Page 4, Section J for all subscribers including spouse and children over the age of 18. If you are electing a PPO plan, signature is also required in Section L for all subscribers.
- Any family member currently pregnant (whether or not listed on this application) or in the process of adoption or surrogacy does not qualify for this program.

Send completed enrollment form to:

[Aetna Advantage Plans, F230
P.O. Box 61516
King of Prussia, PA 19406-9540]

* The HMO product is directly underwritten by Aetna Health Inc. ** The PPO product is underwritten by Aetna Life Insurance Company through a blanket trust arrangement in Delaware.

A. Subscriber Information

Name		Maiden Name of Subscriber/Spouse	
Home Address (Required) - Include Apartment Number, if applicable. Number, Street _____ City, State, ZIP Code _____		Choose desired benefit plan type: <input type="checkbox"/> [Open Access HMO 10 <input type="checkbox"/> HMO 15 <input type="checkbox"/> HMO 20 <input type="checkbox"/> PPO 20 <input type="checkbox"/> PPO 25 <input type="checkbox"/> PPO 30 <input type="checkbox"/> PPO 40 <input type="checkbox"/> High Deductible PPO 1 (HSA Compatible) <input type="checkbox"/> High Deductible PPO 2 (HSA Compatible) <input type="checkbox"/> Dental (Dental option available only with choice of medical plan above) If any PPO plan type is checked, please fill out the "Joinder Agreement" - Section L on Page 5.]	
Billing Address (if different from your home address above; Required) - Include Apartment Number, if applicable. Number, Street _____ City, State, ZIP Code _____			
Telephone Numbers Home () - _____ Work () - _____		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married E-mail Address (optional) _____ Primary Language Spoken (optional) _____	
Is any person listed on this enrollment form a "non-citizen resident" of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes", has that person(s) resided within the United States for the past six (6) consecutive months? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", provide the name(s) and explanation.	
		Reason for Application <input type="checkbox"/> New Enrollment <input type="checkbox"/> Add Spouse/Dependent Child <input type="checkbox"/> Add Dependent Child Only <input type="checkbox"/> Change Existing Benefit Plan Occupation Please check if applicable: <input type="checkbox"/> I am not eligible for health benefits offered by my employer <input type="checkbox"/> I am a sole proprietor or I am self-employed	

B. Individuals Covered/Physician Selection *(Dependent children are covered up to age 19; and between the ages of 19 through 22 with proof of full-time student status.)*

Family Code	Name	Social Security Number	Date of Birth	Age	Sex	Full-time Student Age 19 or Older	Height (ft / in)	Weight (lbs)	Provider ID #*	Previously Seen	Primary Dentist ID #
	Last First M.I.		MM / DD / YYYY		M/F						
APP	Subscriber					Yes N/A				<input type="checkbox"/> Yes <input type="checkbox"/> No	
SP	Spouse					N/A				<input type="checkbox"/> Yes <input type="checkbox"/> No	
01	Dependent					<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No	
02	Dependent					<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No	
03	Dependent					<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No	

*If you choose an HMO product, visit our website (www.aetna.com/DocFind) to request a paper directory to choose your Pennsylvania Primary Care Physician(s) - Use "Aetna Primary Office No." listed in Directory or DocFind®.

If more space is needed to provide information for additional dependents, check here and use a separate sheet of paper. Please staple to the back of this enrollment form.

C. Other Insurance - Please attach copy of Continuation of Coverage Certificate letter for each subscriber, if applicable.

Are you replacing existing coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently have any health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are your spouse/children covered also? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has any subscriber ever filed a claim and/or received benefits from disability insurance or Workmen's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide dates and details.
Are any family members listed above currently enrolled in an Aetna Advantage Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide names and relationship. _____			
Provide name of current (or most recent) health care carrier and coverage termination date (if applicable). Name _____ Term Date _____			
Has any subscriber listed on this enrollment form ever been declined, postponed, had a waiver applied or charged an additional premium for life, disability or health insurance or had such insurance rescinded? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide the following information: Subscriber Name: _____ Explanation: _____			
Subscribers who are currently covered by another carrier must agree to discontinue the other coverage prior to or on the effective date of the Aetna Advantage Plan. <input type="checkbox"/> Yes <input type="checkbox"/> No If No, explain: _____			

D. Effective Date *(Requesting an effective date DOES NOT GUARANTEE underwriting to be completed before the date requested.)*

If Aetna approves my application, please assign an effective date of the <input type="checkbox"/> 1st or the <input type="checkbox"/> 15th of _____. You will be given the requested effective date if Aetna approves the application within 30 days. This date must be no later than 90 days after the signature date (Page 4, Section J) of this enrollment form. This date will be honored provided that Aetna's approval is within 30 days of the requested effective date. If no effective date is requested, Aetna will assign an effective date of the 1st or the 15th of the month following the approval date of my application. No requested effective date will be honored prior to signature date.	Aetna Use Only Y - N - U Group Number: _____ Effective Date: _____
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This enrollment/change form is not proof of coverage.

Subscriber's Social Security Number									

E. Dependent Information

Does any dependent listed in Section B live at another address? <input type="checkbox"/> Yes <input type="checkbox"/> No	If any dependent's last name differs from yours, explain the circumstances.
If Yes, who and what address?	

F. Health History for Individuals and Their Dependents (Include information for all persons applying for coverage.)

Answer all questions & provide complete details to all "yes" answers on Page 3, Section H. Missing information may delay processing this enrollment form..

In the past five (5) years, has any person listed on this enrollment form been diagnosed by a health care provider, received treatment (including prescription medications) or been hospitalized for any of the following conditions or diseases?

F1.	Eyes, Ears, Nose and Throat: <i>Eyes/sight:</i> glaucoma, cataracts, crossed eyes, detached retina, infections; <i>Ears/Hearing:</i> loss of hearing, deafness, infections, eustachian tube dysfunction; <i>Nose/breathing:</i> deviated septum, polyps, adenoiditis, sinusitis; <i>Throat/Swallowing:</i> tonsillitis, strep throat, excessive snoring or sleep apnea, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F2.	Skin Conditions/Disorders: Acne, birthmarks, dermatitis, eczema, fungal infections, psoriasis, keratosis, warts, moles, pre-cancerous lesions, skin cancer or melanoma, 2nd or 3rd degree burns, herpes, scars/keloid, or revisions or cosmetic or reconstructive surgery, excessive sweating, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F3.	Musculoskeletal Conditions/Disorders: Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as strain/sprain, fracture, arthritis, fibromyalgia, gout, herniated disc, joint replacement, internal/external fixations, permanent hardware, amputation/prosthesis, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F4.	Respiratory Conditions/Disorders: Allergies, sinusitis, bronchitis, asthma, pneumonia, shortness of breath, chronic cough, pneumothorax, emphysema, COPD, tuberculosis, fungal infections, difficulty breathing, spitting/coughing up blood, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F5.	Digestive Conditions/Disorders: Infections of mouth/throat/tonsils; problems with jaw or chewing; ulcers, hernia, gastric reflux, colitis, Crohn's Disease, irritable bowel syndrome (IBS), chronic diarrhea, intestinal problems; colon polyps, rectal bleeding or hemorrhoids; diseases of the pancreas, liver or gallbladder; hepatitis A/B/C/other, jaundice, unexplained weight loss or gain, eating disorder, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F6.	Urinary Conditions/Disorders: Bladder infections, kidney infections, stones blood in urine, stress incontinence, urinary frequency, painful/difficult urination, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F7.	Heart and Circulatory Conditions/Disorders: Anemia, bleeding/clotting disorders, thrombocytopenia; varicose/spider veins, Raynauds, phlebitis, thrombosis; enlarged lymph nodes or lymphadenitis; chest pain, angina, high/low blood pressure, hypertension, high cholesterol/lipids, heart murmur, palpitations, congestive heart failure, coronary artery disease, aneurysm, heart attack; bypass surgery/angioplasty, valve replacement, pacemaker or defibrillator, rheumatic fever, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F8.	Metabolic and Endocrine Conditions/Disorders: Diabetes, adrenal/pituitary disorders; lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis; thyroid disorders, AIDS/ARC or any other immune disorders (not including HIV), etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F9.	Brain/Nervous System Conditions/Disorders: Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, confusion, memory loss, Alzheimer's, head injury, stroke; migraine or chronic/severe headaches; narcolepsy, sleep apnea, tremors; multiple sclerosis, seizures/epilepsy, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F10.	Male Reproductive Conditions/Disorders: Infertility, low sperm count, sexual dysfunction, erectile dysfunction, enlarged prostate, prostatitis, undescended testes; genital or anal herpes/warts or sexually transmitted diseases, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F11.	Female Reproductive Conditions/Disorders:	
	a) Pelvic pain, abnormal, menstrual bleeding, absence of menstruation; abnormal PAP smear, endometriosis, ovarian cysts, uterine fibroids, infertility, miscarriage; breast cysts/lumps/fibroids, breast implants; genital warts/herpes or sexually transmitted diseases, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b) Does any proposed female member menstruate? List Names	
	Name _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Name _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Name _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Name _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	
	c) Has it been more than 40 days since any female listed above had her last menstrual period? If Yes, provide name(s) and explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d) Provide the date and result of last Pelvic Exam/Pap Smear for each female over age 18: (If No Pap done, enter N/A.)	
	Name _____ Date _____ Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> N/A	
	Name _____ Date _____ Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> N/A	
	Name _____ Date _____ Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> N/A	
	Name _____ Date _____ Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> N/A	
	e) Is any female subscriber pregnant or in the process of adoption or becoming a surrogate? If Yes, provide subscriber name below.	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Name _____	
F12.	Nervous, Mental and Behavioral: Depression, anxiety, attention deficit, chemical imbalance; bi-polar, obsessive-compulsive or panic disorders; substance abuse, eating disorders; counseling or support group, alcohol or chemical dependence, anorexia/bulimia, schizophrenia, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F13.	Cancer/Tumors: Cysts, tumors or abnormal growths; Hodgkin's disease, leukemia or any other cancer or malignancy, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F14.	Birth Defects/Congenital Abnormalities: Birthmarks, cleft palate/lip, club foot, webbed fingers/toes; developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation; skull /facial or other physical deformities; Cerebral Palsy, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F15.	Other Conditions: Has any subscriber been diagnosed by or received treatment from any doctor or other health care provider for any other condition not listed on this enrollment form?	<input type="checkbox"/> Yes <input type="checkbox"/> No

NOTE: Medical conditions that occur after the signature date and before the effective date of the coverage if approved will be considered in the final underwriting decision. You shall communicate any medical condition occurring during such period.

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G. Health Related Questions (Include information for all persons applying for coverage.)

Answer all questions & provide complete details to all "yes" answers on Page 3, Section H. Missing information may delay processing this enrollment form.

G1.	Is any male subscriber expecting a child or in the process of adoption or surrogacy with anyone whether or not that person is applying for coverage on this enrollment form? If Yes, provide subscriber name below. Subscriber Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
G2.	Has any subscriber been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? If Yes, provide subscriber name(s) below. Subscriber Name: _____ Subscriber Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
G3.	Has any subscriber ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal or IV drugs? Subscriber Name: _____ Type of Drug/Substance: _____ Date Discontinued: _____ Subscriber Name: _____ Type of Drug/Substance: _____ Date Discontinued: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
G4.	Has any subscriber consumed any alcoholic beverage in the last 6 months? (Amount: A drink is 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor.) Subscriber Name: _____ Type: _____ Amount: _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month Subscriber Name: _____ Type: _____ Amount: _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No
G5.	Has any subscriber had any abnormal lab results, X-rays, MRI or other diagnostic test results or physical exam results?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G6.	Has any subscriber been medically advised to undergo further medical testing, treatment or surgery which has not yet been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G7.	Has any subscriber been a patient in a clinic, hospital, surgical center, treatment center or other medical facility in the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G8.	Has any subscriber been diagnosed by or received treatment from any doctor or health care provider for any other condition not listed on this enrollment form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G9.	Has any subscriber smoked or used tobacco product, such as Snuff and/or chewing tobacco, in the last 2 years? If Yes, Provide Subscriber(s) below. Subscriber Name: _____ Date Stopped _____ Subscriber Name: _____ Date Stopped _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
G10.	Has any subscriber taken prescription medications or been advised to take prescription medications in the last 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G11.	Has any subscriber ever seen, received treatment from or consulted any health care provider for any other condition or symptom(s) not listed on this enrollment form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G12.	Is any subscriber a candidate for, or a recipient of, an organ or bone marrow transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G13.	Is any subscriber currently on the waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

H. Detailed Health Information If additional space is needed, check here and use a separate sheet of paper. Please staple to the back of this enrollment form.

1. Provide COMPLETE DETAILS to ALL questions answered "Yes" in Sections F and G.

Family Code*	Ques. No.	Dates From/To	Explain Nature of Illness/Condition	Describe Treatment Received/Recommended and Any Limitations if Applicable	% of Recovery

2. List all medications taken by you and/or your named dependents within the last 12 months.

Family Code*	Ques. No.	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Name of Medication	Dosage and Frequency	Reason/Condition

3. For details and medications indicated above, please list ALL doctors, medical attendants, or practitioners you and/or any named dependents consulted. If none, please state "None."

Family Code*	Question Number and/or Reason	Name, Address and Phone Number of Attending Physician(s)

*See Page 1, Section B.

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H. Detailed Health Information (Continued)

4. List last doctor visit for all family members, including routine check-ups.

Family Code*	Purpose of Visit	Date of Visit	Results of Visit		Name, Address and Phone Number of Physician
			Normal	Abnormal: Give Details	
APP					
SP					
01					
02					
03					

*See Page 1, Section B.

I. Conditions and Agreement Please Read Before Signing Below

IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN. By filling this enrollment form and applying for this coverage, I on behalf of myself and the dependents listed on this Enrollment form, agree to or with the following:

- Aetna may decline this enrollment form. No coverage comes into effect until Aetna approves this enrollment form.
- Coverage and benefits once they come into effect are contingent on timely and accurate payment of premiums and any other contribution provided in the plan documents. If payment of premiums or any other contribution is not paid in time and accurately your coverage will be terminated immediately. If you are terminated for nonpayment of premium, you may no longer be eligible to enroll in any of Aetna's Plans. I agree to make co-payments and any other contributions, as provided for in my plan documents, directly to providers of health care.
- For HMO Plans only: As a condition of coverage, I understand and agree that (with the exception of emergency procedures and certain direct access services as defined in the plan documents) all services, in order to be covered by Aetna, must be performed either by a participating primary care physician, or by the participating specialist, hospital, pharmacy (if applicable) or other provider as authorized by a referral from a participating primary care physician.*
*Some services may require prior authorization from Aetna
- I authorize Aetna to request my and/or my dependents' (those who are applying for coverage under this application) medical records, any prescribed medication history and any other medical or pharmaceutical information to process my application and to make a decision on the approval or disapproval of my and/or my dependents' application. I authorized any physician, other healthcare professionals, hospitals, clinics, labs, pharmacies, pharmacy benefit managers or any other healthcare organization ("Providers") that provided treatment or any other service to me or any of my dependents applying for coverage under this application to disclose the information required by Aetna and described above to Aetna and/or its designated agents.
The existence of such information and documentation as described above shall be disclosed under this Application. I understand that Aetna will rely on such information to: 1) underwrite this application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations for all of the applicants; 2) administer claims and determine or fulfill responsibility for coverage and provisions of benefits; 3) administer coverage; and 4) conduct other insurance operations according to federal and state laws and regulations.
I further authorize Aetna to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities.
I have discussed the terms of this authorization with my spouse and competent adult dependents, and I have obtained their consent to those terms. I understand that this authorization is provided under state law and regulations. This authorization will remain valid for the term of the coverage and if so long thereafter as allowed by law. I understand that Aetna will comply with the HIPAA Privacy Rules and that disclosure of information will be done under the rules of such Federal law. I understand and agree that Aetna will use any information supplied in this Application prior to the effective date of coverage in considering my application, including any medical information.
I understand that I am entitled to receive a copy of this authorization upon request, and that a photocopy is as valid as the original
- I have an obligation of communicating to Aetna in writing any medical conditions which occur to myself or to any of my dependents listed in this Enrollment form after the signature of this Enrollment form and before the effective date of the coverage if approved.
- I understand and agree that, with the exception of Aetna Rx Home Delivery, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
- Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form for insurance or statement of claim containing any material false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

J. Signature(s) Required - All subscribers over the age of 18 must sign and date below. If subscriber is a minor, the enrollment form must be signed by a parent or legal guardian.

I represent that all information supplied on this form is true, complete and correctly recorded by me. I have myself read, understand and agree to the conditions of enrollment on this Enrollment form. I understand that the information supplied in this form will be decisive for the approval of my application and that any material misrepresentation and/or mistake in such information will be reason for cancellation/termination of the coverage for which I am applying. I UNDERSTAND THAT IF MY SIGNATURE/DATE DO NOT APPEAR AND/OR ARE NOT CURRENT AND/OR MY ANSWERS ARE INCOMPLETE, my application will be declined.

Subscriber/Parent or Legal Guardian Signature	Today's Date	Subscriber/Spouse (if applying for coverage)	Today's Date
Subscriber's Dependent Age 18 or Older Signature	Today's Date	Subscriber's Dependent Age 18 or Older Signature	Today's Date

Subscriber's Social Security Number									

K. Important Subscriber Information Please Read Carefully

1. Send a check payable to "AETNA" for one month's premium with your completed enrollment form.
2. Coverage may be declined, or a premium adjustment made, based on information provided to Aetna during the application process. In the case of declination, you will receive a letter notifying you that your application has not been accepted. Specific details will be kept confidential. If all members on the enrollment form are declined coverage, the original check will be returned directly to the subscriber.
3. Do **not** cancel other coverage presently in force until written notification is received from Aetna indicating that your application has been approved and you and covered dependents are in receipt of your member ID card(s) providing the effective date of coverage.

L. PPO Blanket Trust Joinder Agreement To be completed ONLY if the subscriber has chosen in Section A above one of the PPO plans.

I, _____, have chosen one of the PPO benefit plans. I understand that such PPO plans are underwritten by Aetna Life Insurance Company through a blanket trust and that to be able to join such trust I will have to sign and agree to the terms of this Joinder Agreement. I also fully understand and agree that no coverage shall become or remain effective as to myself or any of my dependents if myself or any of my dependents fail to meet minimum underwriting or eligibility requirements of Aetna. I agree to the enrollment criteria as I myself indicated in the "Statement of Enrollment Conditions" section of this form.

I agree to the establishment of an insurance trust fund ("Insurance Fund") for the purpose of implementing a Trust Agreement ("Trust Agreement"), and to the designation of The Bank of New York, (Delaware) as "Trustee" for said Insurance Fund and Trust Agreement.

I, the undersigned, as a Subscriber under the above Trust Agreement: 1) agree to be bound by the terms of the Trust Agreement and the policy (including all of its attached documentation) issued to the Trustee (including any amendments); 2) request coverage for me and/or my dependents under the policy or policies issued to the Trustee (subject to the applicable underwriting requirements of Aetna) and that such coverage become effective as of the date of my or my dependents approval for participation under the Trust Agreement; 3) agree that the covered benefits provided shall be in accordance and shall be subject to the terms of the policy or policies issued to the Trustee of the Insurance Fund; 4) agree to make the required contributions to the Insurance Fund; and 5) also agree that in the case of default, fraud or no payment I will be liable to Aetna for such fraud, or unpaid contributions for the coverage period, and Aetna may terminate coverage for me and /or for my dependents.

Subscriber/Parent or Legal Guardian Signature	Today's Date
Subscriber/Spouse Signature	Today's Date
Subscriber's Dependent Age 18 or Older Signature	Today's Date

M. Statement of Enrollment Conditions

If one or more family members are not approved, Aetna will enroll the approved family members unless otherwise indicated below:

- I, the subscriber, instruct Aetna not to enroll any eligible family members unless all family members are approved for enrollment.

N. Easy Pay

- Yes**, I would like to use Easy Pay. Checking Account Number: _____ Name of Bank: _____
 Name(s) on Checking Account: _____
 Please include a blank check marked "VOID" showing the preprinted account number in addition to the first month's premium check.
- 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, the 1st of every month. I understand that by checking the "Yes" box above and with my application signature on Page 4 (Section J) I am accepting the terms of the Easy Pay Agreement.

NOTE: Terms and conditions of Aetna's Group Agreement shall remain in full force and effect. 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 4, Section J) even if not applying.

O. Statement of Accountability - To be completed if the subscriber cannot or has not completed the enrollment form.

I, _____, personally read and completed the Enrollment form for the subscriber named below because: Subscriber does not read English Subscriber does not speak English Subscriber does not write English
 Other (explain): _____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by:

I also translated and fully explained the "Conditions and Agreement."

Signature of Translator (**Required**) _____ Today's Date (**Required**) _____
 Relationship to Subscriber _____

Subscriber's Social Security Number									

P. Agent Information (If applicable)

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

2. Did you see the proposed subscriber (and spouse, if enrolling) at the time this enrollment form was executed? If no, please explain: Yes No

Signature of Agent (Required)		Today's Date	E-mail Address
Name of Agent (print name)	Agent TIN Number	Agent Street Address	Suite No. / Personal Mail Box (PMB) No.
Telephone Number ()	FAX Number ()	City / State / ZIP Code	
Signature of General Agent (Required, if applicable)		Today's Date	E-mail Address
Name of General Agent (print name)	Agent TIN Number	General Agent Street Address	Suite No. / Personal Mail Box (PMB) No.
Telephone Number ()	FAX Number ()	City / State / ZIP Code	

Q. Instructions: Please refer to the current Aetna Advantage Plan brochure prior to completing this enrollment form.

Please review these instructions.

- The Subscriber must complete the enrollment form. You are responsible to ensure that the information on the enrollment form is correct, complete and truthful.
- Print clearly using blue or black ink. No pencil or correction fluid, please.
- This enrollment form must be received by Aetna's Medical Underwriting team within thirty (30) days from the signature date.
- Any misrepresentation of information on the enrollment form may result in cancellation of coverage.
- Your insurance will become effective only if this enrollment form is approved as enrolled for and the appropriate premium is enclosed.
- A personal check or money order should be made payable to Aetna.

You are ineligible for coverage if Subscriber is currently pregnant (whether or not listed on the enrollment form) or in the process of adoption; or any non-citizen Subscriber has not resided in the U.S. for the last six (6) consecutive months.

Coverage is not guaranteed until approved in writing by Aetna. Do not cancel your current insurance coverage until you have been notified of approval by Aetna and your Aetna coverage is effective.

R. Effective Date

- Dates are assigned to the 1st and 15th of the month. If not selected, underwriting will assign the first available date.

To avoid delays in underwriting, please review for:

- Missing or incomplete information such as:
 - o Weight AND Height
 - o Date of birth
 - o Physician address and telephone number
- Incomplete mailing address information including city, state, and ZIP code.
- Incomplete answers to all enrollment form sections. If a Health Question does not apply to you, the answer should be "No."
- If additional information or explanation is necessary attach extra sheets. **All attachments must be signed and dated.**
- If the Subscriber chooses a PPO product, complete the Joinder agreement section.

S. Billing Information - Carefully read the instructions accompanying each billing type and make sure that your check is attached to the enrollment form.

- **Monthly billing (with monthly bank draft authorization only):** Submit the one (1)-month premium and a voided check and complete the Easy Pay section.

[T. Contact Information

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

Aetna Advantage Plans for Individuals & Families
Mail Stop F230
P. O. Box 61516
King of Prussia, PA 19406-0916

Fax #: 866-223-2041
www.aetna.com]