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. 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 our health insurance department at: 818-654-4548 fax: 818-776-9865

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly bill or monthly EFT from checking account (easy pay)

Step 3

SEND THE COMPLETED APPLICATION TO:

Oleg Skurskiy

18375 Ventura Blvd. # 226

Tarzana, CA 91356

Please make your check payable to: Aetna

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. 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.

If you have questions please contact our office at: 818-654-4548

Thank you for choosing...

Aetna Advantage Plans for Individuals, Families and Self-Employed* – CO

Applicant's Social Security Number

Application ID Number

Instructions:

- Application must be completed by the applicant in blue or black ink. **Please PRINT clearly. (A photocopy of this Application will not be accepted.)**
- **This Application must be completed in its entirety and one (1) form of payment selected or processing time will be delayed.**
- Signature and date is required on **Page 5, Section K** for all applicants including spouse and children age 18 and over.
- Plans are underwritten by Aetna Life Insurance Company.

[Send completed Application to:
Aetna Advantage Plans
PO Box 14015
Lexington, KY 40512-4015**]**

Aetna Use Only | **Effective Date:** | **Number:**
Y – N – U

A. Applicant Information

Name

Maiden Name of Applicant/Spouse

Mailing Address (All Aetna correspondence will be sent to this address.) - Include Apartment Number, if applicable.
Number, Street _____
County _____
City, State, ZIP Code _____

Telephone Numbers
Home ( )
Work ( )
Cell ( )

Marital Status
☐ Single ☐ Married

Billing Address (if you prefer your bill to be mailed to a different address than listed above) - Include Apartment Number, if applicable.
Number, Street _____
City, State, ZIP Code _____

Occupation

E-mail Address

Do you read and write English?
☐ Yes ☐ No

[Choose desired benefit plan type:
Managed Choice Open Access:
☐ 1000 ☐ 1500
☐ 2500 ☐ 5000
☐ Value 2500 ☐ Value 5000 ☐ Value 7500
☐ First Dollar 25
☐ High Deductible 3000 (HSA Compatible)
☐ High Deductible 5000 (HSA Compatible)
☐ Preventive and Hospital Care 1250
☐ Preventive and Hospital Care 3000 (HSA Compatible)
☐ MCOA 750 with Medical $50K CYM
☐ MCOA 1500 with Medical $50K CYM
☐ MCOA 2500 with Medical $50K CYM
☐ MCOA 7500 with Unlimited Primary Care Visits plus Dental
☐ Dental (Dental option only available with Medical.)]

Please check if applicable:
☐ I am eligible for health benefits offered by my employer
☐ I am a sole proprietor or I am self-employed

Is any person listed on this Application a "non-citizen resident" of the United States?
☐ Yes ☐ No

If "Yes", has that person(s) resided within the United States for the past six (6) consecutive months?
☐ Yes ☐ No

Reason for Application:
☐ New Enrollment
☐ Add Spouse/Dependent Child to an Existing Plan
☐ Add Dependent Child to an Existing Plan
☐ Change Existing Benefit Plan
☐ Request for Rate Review

If "No", provide the name(s) and explanation.

B. Individuals Covered *(Dependent children are covered up to age 25.)*

☐ **Check here if more space is needed to provide information on additional dependents. Use a separate sheet of paper and staple to the back of this Application.**

Family Code*	Name Last	First	M.I.	Social Security Number	Date of Birth (MM / DD / YYYY)	Age	Sex (M/F)	Height (ft / in)	Weight (lbs)
APP	Applicant								
SP	Spouse								
01	Dependent								
02	Dependent								
03	Dependent								

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

Do you currently have any health care coverage? ☐ Yes ☐ No | Are your spouse/children covered also? ☐ Yes ☐ No

Are any family members listed above currently enrolled in an Aetna Plan? ☐ Yes ☐ No

If Yes, provide names and relationship. _____ ID# _____

Provide name of current (or most recent) health care carrier and coverage termination date (if applicable).

Name _____ Term Date _____

Has any applicant listed on this Application ever been declined, postponed, had a waiver applied or charged an additional premium for life, disability or health insurance or had such insurance rescinded? ☐ Yes ☐ No If Yes, provide the following information:

Applicant Name: _____ Explanation: _____

Has any applicant ever filed a claim and/or received benefits from disability insurance or Worker's Compensation? ☐ Yes ☐ No

If Yes, provide the following information.

Applicant Name: _____ Date: _____ Explanation: _____

Applicants 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.

☐ Yes ☐ No If No, explain: _____

Are any applicants listed above eligible for Medicare? ☐ Yes ☐ No

Applicant Name: _____ Applicant Name: _____

***In Colorado, a Self-Employed, business group of one may be eligible for a guaranteed issue group health insurance plan under small group reform.**

Applicant's Social Security Number

Application ID Number

D. Health History for Applicant and ALL Dependents *(Include information for all persons applying for coverage.)*

Answer all questions & provide complete details to all "Yes" answers on Page 3, Section F. **Missing information may delay processing this Application.**

In the past ten (10) years, has any person listed on this Application consulted a health care provider, received treatment (including prescription medications) or been hospitalized for any of the following conditions or diseases?

D1.	**Eyes, Ears, Nose and Throat Conditions/Disorders:** *Eyes/sight:* glaucoma, cataracts, crossed eyes, detached retina, corneal transplant, infections; *Ears/Hearing:* loss of hearing, deafness, infections, eustachian tube dysfunction; *Nose/breathing:* deviated septum, polyps, adenoiditis, sinusitis; *Throat/Swallowing:* tonsillitis, strep throat, excessive snoring or sleep apnea, etc.?	☐ Yes ☐ No
D2.	**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 of cosmetic or reconstructive surgery, excessive sweating, etc.?	☐ Yes ☐ No
D3.	**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.?	☐ Yes ☐ No
D4.	**Respiratory Conditions/Disorders:** Allergies, sinusitis, bronchitis, asthma, pneumonia, shortness of breath, chronic cough, collapsed lung, emphysema, COPD, tuberculosis, fungal infections, difficulty breathing, spitting/coughing up blood, etc.?	☐ Yes ☐ No
D5.	**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 gall bladder, hepatitis A/B/C/other, jaundice, Cirrhosis, unexplained weight loss or gain, eating disorder, Gastric Bypass/ Banding, etc.?	☐ Yes ☐ No
D6.	**Urinary Conditions/Disorders:** Bladder infections, kidney infections, stones, blood in urine, stress incontinence, urinary frequency, painful/ difficult urination, cystitis, bed wetting, etc.?	☐ Yes ☐ No
D7.	**Heart and Circulatory Conditions/Disorders:** Anemia, bleeding/clotting disorders, Hemophilia, 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.?	☐ Yes ☐ No
D8.	**Metabolic and Endocrine Conditions/Disorders:** Diabetes, adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis, thyroid disorders, AIDS/ARC (not including the result for the HIV test) or other immune disorder, etc.?	☐ Yes ☐ No
D9.	**Brain/Nervous System Conditions/Disorders:** Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, confusion, memory loss, Alzheimer's, dementia, head injury, stroke**,** migraine headaches or chronic severe headaches**,** narcolepsy, sleep apnea, tremors**,** Multiple Sclerosis, seizures/epilepsy, Muscular Dystrophy, Reflex Sympathetic Dystrophy, etc.?	☐ Yes ☐ No
D10.	**Male Reproductive Conditions/Disorders:** Fertility/infertility, low sperm count, sexual dysfunction, erectile dysfunction, enlarged prostate, prostatitis, undescended testes, genital or anal herpes/warts or sexually transmitted diseases, etc.?	☐ Yes ☐ No
D11.	**Female Reproductive Conditions/Disorders:** a) Pelvic pain, abnormal, menstrual bleeding, absence of menstruation, abnormal PAP Smear, endometriosis, ovarian cysts, uterine fibroids, fertility/infertility, miscarriage, breast cysts/lumps/fibroids, breast implants, genital warts/herpes or sexually transmitted diseases, etc.?	☐ Yes ☐ No
	b) Has it been more than 40 days since any female listed above had her last menstrual period? If Yes, provide name(s) and reason: Name: _____ Reason: _____ _____ _____	☐ Yes ☐ No
	c) Has any ***female*** had an abnormal PAP Smear? If Yes, provide details in **F1**. Date of last normal PAP Smear: Applicant Name: _____ Date: _____	☐ Yes ☐ No
	d) Is any ***female*** applicant pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate? If Yes, provide name: Applicant Name: _____	☐ Yes ☐ No
D12.	**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.?	☐ Yes ☐ No
D13.	**Cancer/Tumors:** Cysts, tumors or abnormal growths**,** Hodgkin's disease, leukemia or any other cancer or malignancy?	☐ Yes ☐ No
D14.	**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.?	☐ Yes ☐ No
D15.	**Other Conditions:** Has any applicant consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s) not listed on this Application?	☐ Yes ☐ 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.

Applicant's Social Security Number

Application ID Number

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

Answer all questions & provide complete details to all "Yes" answers on Section F below.		Missing information may delay processing this Application.
E1.	Is any ***male*** applicant expecting a child or in the process of adoption or surrogacy with anyone whether or not that person is applying for coverage on this Application? If Yes, provide applicant name below. Applicant Name: _____	☐ Yes ☐ No
E2.	Has any applicant been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? If Yes, provide applicant name(s) and dates below. Applicant Name: Date Discontinued:	☐ Yes ☐ No
E3.	Has any applicant ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal or controlled IV drugs? If Yes, provide applicant name(s) below. Applicant Name: Type of Drug/Substance: Date Discontinued:	☐ Yes ☐ No
E4.	Has any applicant 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.) Applicant Name: Type: Amount: per ☐ Day ☐ Week ☐ Month per ☐ Day ☐ Week ☐ Month	☐ Yes ☐ No
E5.	Has any applicant been convicted of a DUI (Drunk Driving Violation)? If Yes, provide applicants name(s), state(s), and date(s) below. Applicant Name: State: Date:	☐ Yes ☐ No
E6.	Has any applicant been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), diseases associated with AIDS or other immune system disorders, or ever tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No
E7.	Has any applicant had any ***abnormal*** lab results, X-rays, MRI or other diagnostic test results or physical exam results?	☐ Yes ☐ No
E8.	Has any applicant been medically advised to undergo further medical testing, treatment or surgery which has not yet been completed?	☐ Yes ☐ No
E9.	Has any applicant been a patient in an outpatient clinic, hospital, surgical center, treatment center or other medical facility?	☐ Yes ☐ No
E10.	Has any applicant seen any health care provider for any condition, signs or symptoms which have not yet been diagnosed?	☐ Yes ☐ No
E11.	Has any applicant smoked or used tobacco products, such as snuff and/or chewing tobacco, in the last 2 years? If Yes, Provide Applicant(s) below. Applicant Name: Date Stopped:	☐ Yes ☐ No
E12.	Has any applicant taken prescription medications or been advised to take prescription medications in the last 2 years?	☐ Yes ☐ No
E13.	Has any applicant ever seen, received treatment from or consulted any health care provider for any other condition or symptom(s) not listed on this Application?	☐ Yes ☐ No
E14.	Is any applicant a candidate for, or a recipient of, an organ, bone marrow or stem cell transplant?	☐ Yes ☐ No
E15.	Is any applicant currently on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	☐ Yes ☐ No

F. Detailed Health Information

☐ ***Check here if additional space is needed. Use a separate sheet of paper and staple to the back of this Application.***

1. Provide COMPLETE DETAILS to ALL questions answered "Yes" in Sections D and E.

Family Code*	Ques. No.	Dates From	Dates To	Explain Nature of Illness/Condition	Describe Treatment Received/Recommended and Any Limitations if Applicable	Do you consider yourself fully recovered
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Continued

***See Page 1, Section B.**

Applicant's Social Security Number									

Application ID Number									

F. Detailed Health Information (Continued)

2. List all prescription medications and/or doctors' samples taken by you and/or your named dependents within the last 2 years.

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

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

Family Code*	No Visit	Purpose of Visit	Date of Visit	Results of Visit	Name, Address and Phone Number of Physician
APP					
SP					
01					
02					
03					

***See Page 1, Section B.**

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

If Aetna approves my Application, I am requesting an effective date of the ☐ 1st or the ☐ 15th of _____ (month).
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 5, Section K)** of this Application. This date will be honored provided that Aetna's approval is within 30 days of the requested effective date. No requested effective date will be honored prior to or on the signature date.

H. Statement of Enrollment Conditions

Each member of the family will be medically underwritten separately and assigned a separate medical coverage based on their own health risk.
If one or more family members are not approved, Aetna will cover the approved family members unless otherwise indicated below.

☐ I, the applicant, instruct Aetna not to cover any eligible family members unless all family members are approved for coverage.

☐ I prefer to receive written communication regarding my Application via email.

I. Race/Ethnicity - Optional

Family Code	(This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)		
APP	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian– 04 ☐ Other – 05 _____	01	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian– 04 ☐ Other – 05 _____
SP	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian– 04 ☐ Other – 05 _____	02	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian– 04 ☐ Other – 05 _____
		03	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian– 04 ☐ Other – 05 _____

Applicant's Social Security Number

Application ID Number

J. Conditions and Agreement - Please Read Before Signing Below.

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

1. Aetna may decline this Application. No coverage comes into effect until Aetna approves this Application.
2. 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.
3. 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 authorize 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 Application 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. This authorization may be revoked by me at any time by completing the form entitled "Revocation of Authorization Previously Given to Aetna" available by calling the member service number on your ID card. 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.
4. 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 Application after the signature of this Application and before the effective date of the coverage if approved.
5. 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.
6. Information on agent's compensation is available from your agent or at Aetna.com.
7. Any person who knowingly and with intent to defraud any insurance company or other person files an Application 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.

K. Signature(s) Required - All applicants age 18 and over must sign and date below.
If applicant is a minor, the Application 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 Application. I understand that the information supplied in this form will be decisive for the approval of my enrollment and that any misrepresentation and/or mistake in such information will be reason for cancellation/termination of the coverage for which I am enrolling.

I UNDERSTAND THAT IF MY SIGNATURE/DATE DO NOT APPEAR AND/OR ARE NOT CURRENT AND/OR MY ANSWERS ARE INCOMPLETE, my enrollment will be declined.

Once you submit this Application you may be contacted at any time via telephone by an Aetna representative to complete your enrollment and the underwriting process. You will be able to confirm the identity of the person calling. Please do not answer any questions if you are not satisfied with the identity of the caller. The person calling will give you a number to confirm their identity. Please call if you have any doubts or problems with respect to the call or the process during the call.

Applicant/Parent or Legal Guardian Signature	**Today's Date**	**Applicant/Spouse Signature** *(If enrolling for coverage)*	**Today's Date**
Applicant's Dependent *(Not a minor)*	**Today's Date**	**Applicant's Dependent** *(Not a minor)*	**Today's Date**

Applicant's Social Security Number

Application ID Number

L. Determination of Self-Employed Business Group of One

All Applicants must complete the questions below to determine if you meet the legal definition of a "self-employed business group of one" in Colorado.

L1.	Are you either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees?	☐ Yes ☐ No
L2.	Have you carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage?	☐ Yes ☐ No
L3.	Do you have gross income from your self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years? **Note:** Substantial part of your income means income derived from business activities of the business group of one that are sufficient to pay for the annual premiums for the business group of one's health benefit plan?	☐ Yes ☐ No
L4.	Do you work a minimum of 24 hours a week on a permanent basis? If you answered No to ANY of the questions above, please sign and date the form below. If you answered Yes to ALL of the above questions, please complete the following information:	☐ Yes ☐ No

Full Name	**Name of Other Coverage**	**Effective Date of Other Coverage**
Spouse		
Dependent		
Dependent		
Dependent		

Please read and sign the following disclosure required by Colorado law.

I, _____, meet the definition of a self-employed business group of one as attested to on the
(name of applicant)
above Determination of Self-Employed Business Group of One Form. I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three (3) year period. I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of plan design, my age, my health status and that of my dependents, overall cost and utilization trends, and tobacco use. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited to plan design, the carrier's overall cost and utilization trends ("index rate"), my age, my family size, and a factor that reflects the cost of care where I live. I have been given a health plan description form showing the benefits under Colorado's small group Standard Health Benefit Plans. I have also been given a Colorado Health Plan Description Form for the plan for which I am applying. I, hereby attest that the answers to the questions contained in this form are true and correct.

Applicant's Signature	**Date**

M. Important Applicant Information - Please Read Carefully

1. Coverage may be declined, or a premium adjustment made, based on information provided to Aetna during the Application process. In the case of denial, 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 Application are denied coverage, the original check will be returned directly to the applicant.
2. 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.

Applicant's Social Security Number

Application ID Number

PAYMENT OPTIONS – Please select the method of payment for your initial application and subsequent premium payments.

N. Initial Payment

- ☐ Easy Pay (complete the EFT information below)
- ☐ Credit Card (complete the credit card information below)
- ☐ Personal Check or Money Order (made payable to "Aetna" and attached to your completed application)

O. Recurring or subsequent Payment

- ☐ Easy Pay (complete the EFT information below)
- ☐ Bill me monthly

Easy Pay (Electronic Fund Transfer)

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 selecting "Easy Pay" above and with my Application signature on **Page 5 (Section K)**. 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 upon approval of your application. Please be advised that such rate adjustment may result in an increase of 0% to 100% of 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 (**Page 5, Section K**) 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 <u>initial premium payment only</u> and will be charged upon approval of your Application. You must elect EFT or monthly billing for your next premium payment.

Any rate adjustment made in accordance with the underwriting process will be automatically charged to your account upon approval of your Application. Please be advised that such rate adjustment may result in an increase of **<u>0% to 100% of the standard premium</u>**.

P. Statement of Accountability - To be completed if the applicant cannot or has not completed the Application.

I, _____, personally read and completed the Individual Application for the applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant 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 Applicant _____

Applicant's Social Security Number

Application ID Number

Q. Insurance Producer Information (if applicable)

	General Agent	Insurance Broker
1. Are you aware of any information not disclosed on this Application relating to the health, habits or reputation of any person listed on this Application which might have a bearing on the risk? If Yes, please attach explanation.	☐ Yes ☐ No	☐ Yes ☐ No
2. Did you see the proposed applicant (and spouse, if applying) at the time this Application was executed? If No, please explain:	☐ Yes ☐ No	☐ Yes ☐ No

Signature of Insurance Producer (Required)		**Signature of General Agent** (Required, if applicable)	
Date	E-mail Address oleg@findppo.com	Date	E-mail Address
Name of Insurance Producer or Agency to be assigned as Broker or Record (print name) Oleg Skurskiy		Name of General Agent (print name)	
TIN Insurance Producer or Agency to be assigned as Broker or Record 8188154		Agent TIN Number	
Street Address (Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code) 18375 Ventura Blvd. # 226 Tarzana, CA 91356		Street Address (Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)	
Telephone Number 818-654-4548	Fax Number 818-776-9865	Telephone Number ( )	Fax Number ( )

R. Aetna Sales Representative

Last Name of Sales Representative (print name)	First Name of Sales Representative (print name)

S. Instructions

Please review these instructions.

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

You are ineligible for coverage if as a non-citizen Applicant you have not resided in the U.S. for the last six (6) consecutive months..

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

T. 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:
  - Weight AND Height
  - Date of birth
  - Physician address and phone number
- Incomplete mailing address information including city, state, and ZIP code.
- Incomplete answers to all Application 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.**

U. Payment Options

Carefully read the instructions accompanying each payment option (Page 7, Sections N, and O).

[V.Contact Information

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

Aetna Advantage Plans
PO Box 14015
Lexington, KY 40512-4015

Fax #: 866-892-8396
www.aetna.com]

Additional Coverage Information – CO

Applicant's Social Security Number

Application ID Number

- You normally do not require more than one policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy.
- If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.

A. To the best of your knowledge:

1. Do you have another insurance policy or contract in force? a) If Yes, provide company name and policyholder number: Company Name _____ Policyholder Number _____	☐ Yes ☐ No
b) If Yes, do you intend to replace your current accident and sickness insurance with this policy (contract)?	☐ Yes ☐ No
2. Do you have any other accident and sickness insurance that provides benefits similar to this accident and sickness policy? a) If Yes, provide company name and policyholder number: Company Name _____ Policyholder Number _____	☐ Yes ☐ No
b) If Yes, provide type of policy: Type of Policy _____	
3. Are you covered for medical assistance through the state Medicaid program?	☐ Yes ☐ No
a) As a Specified Low Income Medicare Beneficiary (SLMB)?	☐ Yes ☐ No
b) As a Qualified Medicare Beneficiary (QMB)?	☐ Yes ☐ No
c) For other Medicaid medical benefits?	☐ Yes ☐ No

B. Producers shall list any other accident and sickness insurance they have sold to the applicant.

1. List policies sold which are still in force.
2. List policies sold in the past five (5) years which are no longer in force.

Notice To Applicant Regarding Replacement of Accident and Sickness Insurance

[Aetna Advantage Plans
PO Box 14015
Lexington, KY 40512-4015]

According to the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Aetna Life Insurance Company. Your new policy will provide 10 days of free look period, days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement To Applicant By Issuer or Producer
I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s) (check one):

- ☐ Additional benefits
- ☐ No change in benefits, but lower premiums
- ☐ Fewer benefits and lower premiums
- ☐ Other (please specify): _____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.
2. State law provides that your replacement policy or contract may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If, you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Producer's or Other Representative's Signature*	Date
Print Name and Address of Issuer or Producer	
Applicant's Signature	Date

***Signature not required for direct response sales.**