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: 818-987-5000 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: 818-987-5000

Thank you for choosing...

aetna℠

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

Applicant's Social Security Number

Application ID Number

Instructions and Important Information:

- **Please PRINT clearly**. Application must be completed by the Applicant in blue or black ink. **No pencil or correction fluid. (A photocopy of this application will not be accepted.)**
- The Applicant must complete the application. You are responsible to ensure that the information on the application is correct, complete, and truthful.
- Any intentional misrepresentation of material fact on the application may result in cancellation of coverage.
- The application must be received by Aetna's underwriting department within 30 days from the signature date.
- **This application must be completed in its entirety and one (1) form of payment selected or processing time will be delayed.**
- Your insurance will become effective only if this application is approved as applied for, and the appropriate premium is enclosed.
- Coverage is not guaranteed until approved in writing by Aetna. DO NOT cancel your current insurance coverage until you have been notified of your approval by Aetna and your Aetna coverage is in effect.
- **Signature and date is required on Page 9, Section Q for all applicants including spouse/domestic partner/domestic partner and children age 18 and over.**
- Plans are underwritten by Aetna Life Insurance Company and Aetna Health Inc. Once you submit this application, you may be contacted at any time via telephone by an Aetna representative to complete your application and the underwriting process. Please do not answer any questions if you are not satisfied with the identity of the caller. Please call **1-866-898-3267** if you have any questions or concerns.

Send completed application to:

Aetna Advantage Plans
PO Box 14381
Lexington, KY 40512-4381

Aetna Use Only

Prior Coverage: ☐ **Y** ☐ **N** ☐ **U**

Effective Date:

A. Applicant Information

Name

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

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 _____

Telephone Numbers
Home ( ) Work ( ) Cell ( )

Marital Status	Occupation	E-mail Address	Do you read and write English?
☐ Single ☐ Married ☐ Domestic Partner			☐ Yes ☐ No

**You have the option to choose this Consumer Choice of Benefits Health Insurance Plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. This standard health benefit plan may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy.

Choose desired benefit plan type:

Aetna Open Access® Managed Choice®:

☐ OAMC 2500** ☐ OAMC 3500** ☐ OAMC 5000 ☐ OAMC 7500**
☐ OAMC Value 1750** ☐ OAMC Value 3000** ☐ OAMC Value 5000** ☐ OAMC Value 10000**
☐ OAMC High Deductible 3500** (HSA Compatible) ☐ OAMC High Deductible 5500** (HSA Compatible)
☐ OAMC Preventive and Hospital Care 2750** (HSA Compatible)

PPO: ☐ PPO 2500** ☐ PPO 3500** ☐ PPO 5000 ☐ PPO 7500**
☐ PPO Value 1750** ☐ PPO Value 3000** ☐ PPO Value 5000** ☐ PPO Value 10000**
☐ PPO High Deductible 3500** (HSA Compatible) ☐ PPO High Deductible 5500** (HSA Compatible)
☐ PPO Preventive and Hospital Care 2750** (HSA Compatible

☐ Dental (Dental option only available with medical)

All products not available in all counties. Please refer to the state map in the Aetna Advantage Brochure.

Reason for application:

☐ New Enrollment for Aetna Advantage Plans
☐ Add Spouse/Domestic Partner/Dependent Child to an Existing Plan
☐ Add Dependent Child Only to an Existing Plan
☐ Change Existing Benefit Plan (Existing Advantage Plan Member Only)
☐ Request for Rate Review

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

*** In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans.**

Applicant's Social Security Number

Application ID Number

B. Individuals to be Covered ***(Dependent children are covered up to age 26.)***

☐ ***Check here if more space is needed to provide information for 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/DP	Spouse/Domestic Partner								
01	Dependent								
02	Dependent								
03	Dependent								

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

Are you replacing existing coverage? ☐ Yes ☐ No	Are your spouse/domestic partner/children also covered? ☐ Yes ☐ No
Provide name of current (or most recent) health care carrier and coverage termination date (if applicable). Name: _____ Term Date: _____	
Are any family members listed above currently enrolled in any Aetna Plan? ☐ Yes ☐ No If "Yes," provide names and relationship: _____ ID No.: _____	
Has any person ever filed a claim and/or received benefits from disability insurance or Workers' Compensation? ☐ Yes ☐ No If "Yes," provide the following information. Name: _____ Date: _____ Explanation: _____	

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

Answer all questions and provide complete details to all "Yes" answers on Page 5, Section F.	**Missing information may delay processing this application.**
In the past ten (10) years, has any person listed on this application had any signs or symptoms that would cause an ordinary prudent person to seek advice or treatment or had treatment or consultation recommended, received treatment from a health care provider (including prescription medications) or been hospitalized for any of the following conditions or diseases listed in Sections E and F?	

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	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D2.	**Skin Conditions/Disorders:** Acne, psoriasis, keratosis Birthmarks, dermatitis, eczema, fungal infections, warts, herpes, excessive sweating Moles/pre-cancerous lesions, skin cancer, or melanoma 2nd or 3rd degree burns, scars/keloid, or revisions of cosmetic or reconstructive surgery	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D3.	**Musculoskeletal Conditions/Disorders:** Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as: Strain/sprain, back or neck pain, fibromyalgia, gout Fracture, internal/external fixations, permanent hardware, amputation/prosthesis Arthritis, joint replacement, herniated disc	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D4.	**Respiratory Conditions/Disorders:** Allergies, sinusitis, bronchitis, asthma, pneumonia, collapsed lung, spitting/coughing up blood Shortness of breath, chronic cough, emphysema, COPD, difficulty breathing Tuberculosis, fungal infections	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

continued

Applicant's Social Security Number

Application ID Number

D. Health History for Applicant and ALL Spouse/Domestic Partner/Dependents (*Continued*)

D5.	**Digestive Conditions/Disorders:** Infections of mouth/throat/tonsils Problems with jaw or chewing, ulcers, hernia, gastric reflux, unexplained weight loss or gain, eating disorder, Gastric Bypass/Banding 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	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D6.	**Urinary Conditions/Disorders:** Bladder infections, kidney infections, stones, blood in urine Stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D7.	**Heart and Circulatory Conditions/Disorders:** Anemia, bleeding/clotting disorders, Hemophilia, thrombocytopenia, Varicose/spider veins, Raynauds, phlebitis, thrombosis, enlarged lymph nodes or lymphadenitis High blood pressure (hypertension), low blood pressure, high cholesterol/lipids Chest pain, angina, heart murmur, palpitations, congestive heart failure, coronary artery disease, rheumatic fever Heart attack, bypass surgery/angioplasty, leaky or prolapsed valve, valve replacement, pacemaker or defibrillator, aneurysm	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D8.	**Metabolic and Endocrine Conditions/Disorders:** Diabetes, Insulin Resistance, Metabolic Syndrome, Thyroid disorders Adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis Or other immune disorder (not including the result for the HIV test)	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D9.	**Brain/Nervous System Conditions/Disorders:** Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, narcolepsy, sleep apnea Confusion, memory loss, Alzheimer's, dementia, head injury, seizures/epilepsy Stroke, paralysis, migraine headaches or chronic severe headaches Tremors, Multiple Sclerosis, Muscular Dystrophy, Reflex Sympathetic Dystrophy (RSD)	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D10.	**Male Reproductive Conditions/Disorders:** Fertility/infertility treatment, low sperm count, sexual dysfunction Erectile dysfunction, enlarged prostate, prostatitis, undescended testes Genital or anal herpes/warts, sexually transmitted diseases	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D11.	**Female Reproductive Conditions/Disorders:** a) Pelvic pain, abnormal menstrual bleeding, endometriosis, ovarian cysts, absence of menstruation Abnormal PAP smear, uterine fibroids, fertility/infertility treatment, miscarriage, genital warts/herpes or sexually transmitted diseases Breast cysts/lumps/fibroids, breast implants	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
	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(s): _____ Reason(s): _____ _____ _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
	c) **Has any female had an abnormal PAP smear? If "Yes," provide details in F1**. Date of last normal PAP smear. Name: _____ Date: _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
	d) Is any female applying for coverage pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate? If "Yes," provide name: Name: _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D12.	**Nervous, Mental and Behavioral:** Depression, anxiety, obsessive-compulsive or panic disorders, eating disorders, anorexia/bulimia Attention deficit, chemical imbalance, bi-polar, schizophrenia Substance abuse, counseling or support group, alcohol or chemical dependence	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D13.	**Cancer/Tumors:** Cysts, tumors or abnormal growths Hodgkin's disease, leukemia or any other cancer or malignancy	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

continued

Applicant's Social Security Number

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D. Health History for Applicant and ALL Spouse/Domestic Partner/Dependents (*Continued*)

D14.	**Birth Defects/Congenital Abnormalities:** Cerebral Palsy, Birthmarks, developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation Cleft palate/lip, club foot, webbed fingers/toes, skull/facial or other physical deformities	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D15.	**Other Conditions:** Has any person applying for coverage consulted with or received treatment from any doctor or other health care provider for any other known condition or symptom(s) not listed on this application?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

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

Answer all questions and provide complete details to all "Yes" answers on Page 5, Section F.	**Missing information may delay processing this application.**	
E1.	Is any ***male*** 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 name below. Name: _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E2.	Has any person applying been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? If "Yes," provide name(s) below. Name: _____ Name: _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E3.	Has any person applying ever used illegal or controlled drugs, or substances such as marijuana, cocaine, methamphetamines, illegal, or controlled IV drugs in the last 10 years? If "Yes," provide name(s)/details below. Name: Type of Drug/Substance: Date Discontinued: _____ _____ _____ _____ _____ _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E4.	Has any person applying 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.) If "Yes," provide name(s)/details below. Name: Type: Amount: _____ _____ _____ per ☐ Day ☐ Week ☐ Month _____ _____ _____ per ☐ Day ☐ Week ☐ Month	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E5.	Has any person applying been convicted of a DUI (drunk driving violation)? If "Yes," provide name(s), state(s) and date(s). Name: State: Date: _____ _____ _____ _____ _____ _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E6.	Has any applicant been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS-Related Complex) or tested positive for HIV (Human Immunodeficiency Virus)?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E7.	Has any person applying received any lab results, X-rays, MRI or other diagnostic test results or physical exam results from a physician or medical practitioner that were considered **abnormal**?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E8.	Has any person applying been advised to undergo further medical testing, treatment or surgery which has not yet been completed?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E9.	Has any person applying been a patient in an outpatient clinic, hospital, surgical center, treatment center or other medical facility?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E10.	Has any person applying seen any health care provider for any condition, signs, or symptoms which have not yet been diagnosed?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

continued

Applicant's Social Security Number

Application ID Number

E. Health Related Questions (*Continued*)

E11.	Has any person applying smoked or used tobacco products, such as snuff and/or chewing tobacco, in the last 12 months? If "Yes," provide name(s) below. Name: Date Stopped: _____ _____ _____ _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E12.	Has any person applying taken prescription medications or been advised to take prescription medications in the last 2 years?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E13.	Has any person applying 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 ☐ App ☐ SP/DP ☐ Dep
E14.	Is any person applying a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E15.	Is any person applying currently on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

F. Detailed Health Information

☐ ***Check here if more 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 Recommended and/or Received	Do you consider yourself "Fully Recovered"
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

2. List all prescription medications and/or doctor's samples taken by you and/or your named spouse/domestic partner/dependents within the last 2 years.

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

***See Family Code explanation on Page 2, Section B.**

continued

Applicant's Social Security Number

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F. Detailed Health Information (*Continued)*

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

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

4. List the 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/DP					
01					
02					
03					

***See Family Code explanation on Page 2, 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 ☐ 15th _____ (month).

Aetna will assign the effective date after underwriting is completed and you are approved for coverage. 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 his or her 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.)				01	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian– 04 ☐ Other – 05 _____			
APP	☐ White – 01	☐ African American or Black – 02	☐ Hispanic or Latino – 03	☐ Asian– 04	02	☐ White – 01	☐ African American or Black – 02	☐ Hispanic or Latino – 03	☐ Asian– 04
	☐ Other – 05 _____					☐ Other – 05 _____			
SP	☐ White – 01	☐ African American or Black – 02	☐ Hispanic or Latino – 03	☐ Asian– 04	03	☐ White – 01	☐ African American or Black – 02	☐ Hispanic or Latino – 03	☐ Asian– 04
	☐ Other – 05 _____					☐ Other – 05 _____			

Applicant's Social Security Number

Application ID Number

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

Initial Payment

☐ Easy Pay (complete the EFT information below)
☐ Credit Card (complete the credit card information below)

Recurring or Subsequent Payment

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

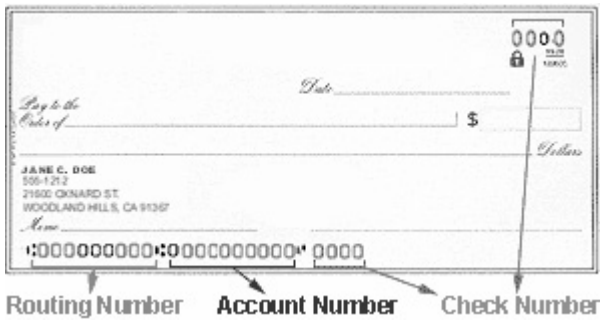
Easy Pay (Electronic Fund Transfer – EFT)

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 on **Page 9, Section Q**, 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 9, Section Q**) 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. 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. Please be advised that such rate adjustment may result in an increase of **0% to 100% of the standard premium**.

K. Statement of Accountability - To be completed if the applicant cannot complete the application.

I _____ in representation of the applicant, 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 the "Conditions and Agreement" under **Section P** to the applicant.

Signature of Representative ***(Required):*** _____ Today's Date ***(Required)***: _____

Print Name: _____

Street Address: _____

City, ZIP Code, State: _____ Phone Number: _____

Applicant's Social Security Number

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L. Insurance Producer Attestation – To be completed by Insurance Producer/General Agent.

	Insurance Broker		General Agent	
1. Did you see the proposed applicant (and spouse/domestic partner, if applying) at the time this application was executed? If "No," please explain.	☐ Yes	☐ No	☐ Yes	☐ No
2. To the best of your knowledge, is the information on this application complete and accurate? If "No," please explain.	☐ Yes	☐ No	☐ Yes	☐ No
3. You have explained in easy to understand English (or via translation where applicable) the risk to the applicant of providing inaccurate information on this application, and that the applicant fully understands your explanation.	☐ Yes	☐ No	☐ Yes	☐ No
4. Did the primary applicant complete this application and review prior to signing? If "No," please explain.	☐ Yes	☐ No	☐ Yes	☐ No

Signature of Insurance Producer (Required if applicable)		**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 of Record (print name) Oleg Skurskiy		Name of General Agent (print name)	
TIN of Producer or Agency to be assigned as Broker of Record 8188154		Agent TIN Number	
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code) 18375 Ventura Blvd. # 226 Tarzana, CA 91356		Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)	
Telephone Number 818-987-5000	Fax Number 818-776-9865	Telephone Number ( )	Fax Number ( )

M. Aetna Sales Representative

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

N. Contact Information

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

Aetna Advantage Plans
PO Box 14381
Lexington, KY 40512-4381

Fax #: 866-892-8396

Website for information: www.aetna.com/members/individual

O. Important Reminders – Please Review Prior To Signing

To avoid delays in underwriting, please review this application for missing or incomplete information such as:

- Height and Weight
- Date of Birth
- Physician's address and phone number
- Complete mailing address information, including: city, state and ZIP code
- Complete answers to all Health History questions
- First and Recurring payment options
- Social Security Number for each applicant on **Page 2, Section B**
- If additional information or explanation is necessary, attach extra sheets to the back of this application. **All attachments must include primary Applicants Last Name, First Name and be signed and dated.**

Applicant's Social Security Number

Application ID Number

P. 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 spouse/domestic partner and/or dependents listed on this application ("Applicant(s)"), 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. If payment of premiums are not paid on time and accurately, your coverage will be terminated in accordance with the Grace Period provisions. If you are terminated for nonpayment of premium, you may no longer be eligible to enroll in any of Aetna's Plans.
3. I authorize Aetna to request Applicant(s) medical records, any prescribed medication history and any other medical or pharmaceutical information to process this application and to make a decision on the approval or disapproval of this 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 Applicant(s) that are applying for coverage under this application to disclose the information required by Aetna and described above to Aetna and/or its designated agents. I understand that I may revoke this authorization at any time while Aetna is determining eligibility for the coverage requested. To do so, I must notify Aetna in writing prior to the issuance of the policy. Revocation of this authorization will result in closure of this application.
4. 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 persons applying for coverage; 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 authorize Aetna to use such information and to disclose such information to affiliates, Providers, payers, 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. This authorization will remain valid for twenty-four (24) months. I understand that Aetna will comply with the HIPAA Privacy Rules and that disclosure of such information will be done in accordance with applicable law.
5. I understand that I am entitled to receive a copy of this application upon request, and that a photocopy is as valid as the original.
6. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice.
7. Agents may be compensated based on an individual's enrollment in this plan. Information on insurance agent/broker compensation is available from your agent or at Aetna.com.

Q. Signature(s) Required - All persons applying for coverage age 18 and over must sign and date below.

I understand that if my signature/date do not appear and/or are not current and/or my answers are incomplete this application will be declined.

I have an obligation of communicating to Aetna in writing any medical conditions which occur to Applicant(s) listed in this application after the signature date on this application and before the effective date of the coverage, if approved.

Any person who knowingly or willfully makes a false or fraudulent statement or representation on or with reference to an application for insurance may be guilty of insurance fraud.

By signing below, Applicant(s) agree to the statements listed above on this application and represent that all information supplied on this form is true and complete to the best of their knowledge. Applicant(s) have read, understand, and agree to the conditions of enrollment on this application. Applicant(s) understand that the information supplied in this form will be decisive for the approval of this application and that any intentional misrepresentation of material fact that impacts acceptance of the risk of coverage by Aetna will be reason for cancellation/termination of the coverage for which Applicant(s) are applying.

If adding dependents: I represent that the child/children listed on this form are my legal dependents.

I understand that Aetna requires a copy of my child's birth certificate, adoption decree or legal documentation of responsibility for purposes of dependent verification.

NOTE: Failure to provide such documentation within 60 days of the date of birth or adoption (unless otherwise required by the state).

Applicant's Signature	Today's Date
Applicant's Spouse/Domestic Partner (If applying 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

R. Election of PPO 2500, 3500, 7500, PPO Value 1750, 3000, 5000, 10000, PPO High Deductible 3500, PPO High Deductible 5500, and Preventative and Hospital Care 2750

Election of Open Access® Managed Choice® 2500, 3500, 7500, OAMC Value 1750, 3000, 5000, 10000, OAMC High Deductible 3500, Deductible 5000 and Preventative and Hospital Care 3000

By choosing one of the Consumer Choice Benefit plans listed in the title above, you have elected to choose a plan that may provide fewer health benefits than state mandated by Texas.

TEXAS DEPARTMENT OF INSURANCE REQUIRED DISCLOSURE NOTICE FOR ALL INDIVIDUAL INDEMNITY CONSUMER CHOICE BENEFIT PLANS ISSUED IN TEXAS

As required by 28 TAC §21.3530, I have been informed that the Consumer Choice Health Benefit Plan that I am purchasing does not include all state mandated health insurance benefits. I understand that the following benefits are provided at a reduced level from what is mandated, or are excluded completely from the plan:

Mandated Benefit Description	Benefit Reduced	Benefit Excluded
Telemedicine/Telehealth: Article 21.53F Texas Insurance Code Medical services, some of which may be conducted without a face-to-face consultation.		Not covered.
Maternity Benefits: Section 21.404(6), Subchapter E, Title 28 Texas Administration Code.		Not offered. Complications of pregnancy are covered.
Mastectomy Minimum Length of Stay Following Mastectomy or Lymph Node Dissection		Minimum length of stay Article 21.52G, Texas Insurance Code determined by attending physician in consultation with patient. May vary from statutory minimum
Mental/Nervous Disorders With Demonstrable Organic Disease Section 3.3057(d), Exhibit A, Subchapter S, Title 28, Texas Administrative Code		Not covered.
Certain Therapies for Children With Developmental Delays Article 21.53F, Section 9, Texas Insurance Code		Not covered.
HIV, AIDS, or HIV-Related Illnesses: Articles 3.70-3A Texas Insurance Code; Section 3.3057(d), Exhibit A, Subchapter S, Title 28, Texas Administrative Code		Not covered.

I also understand that if I purchase a health plan that excludes or reduces coverage for a certain condition, I may be limiting my ability to obtain individual insurance coverage for that condition, in the event the health of any individual covered under the plan changes. I understand that I may obtain from the Department of Insurance a consumer brochure with more information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at **www.tdi.state.tx.us/consumer/indexc.html**, or by calling 1-800-252-3439.

NOTE: This form must be retained by the carrier issuing the policy and must be provided to the Commissioner of Insurance upon request. **You have the right to a copy of this written disclosure statement free of charge.** A new form must be completed upon each subsequent renewal of this policy.

By signing this document, I affirm that I was offered a benefit plan that contains the state mandated health insurance benefits and that I have elected to purchase this Consumer Choice Benefit Plan.

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

aetna SM

HIPAA Update

To the Applicant/Spouse/Domestic Partner and Dependent age 18 and older

Please be advised that Aetna may request Applicant(s) medical records, any prescribed medication history and any other medical or pharmaceutical information to process this enrollment form and to make a decision on the approval or disapproval of this enrollment form. Your application authorizes 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 Applicant(s) that are applying for coverage under this enrollment form to disclose the information required by Aetna and described above to Aetna and/or its designated agents.

Aetna may condition eligibility for enrollment in an Aetna health plan; if you are enrolled, Aetna may not condition eligibility for treatment, payment or benefits, on whether or not you sign this authorization. You understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

You may revoke this authorization at any time while Aetna is determining eligibility for the coverage requested. To do so, you must notify Aetna in writing prior to the issuance of the policy. Revocation of this authorization will result in closure of this application.