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: fax:

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:

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:

Thank you for choosing...

Aetna

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

Applicant's Social Security Number

Application ID Number

Send completed Application to:
Aetna Advantage Plans
PO Box 14381
Lexington, KY 40512-4381

(PLEASE NOTE: HIPAA ELIGIBLE APPLICANTS WILL NOT BE DENIED COVERAGE)
TO COMPLY WITH CALIFORNIA LAW, WHEREVER THE TERM "SPOUSE/DOMESTIC PARTNER" APPEARS IT SHALL BE CONSTRUED TO INCLUDE DOMESTIC PARTNER.

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 information 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.
- You are ineligible for coverage, if as a non-citizen of the United States, you have not resided in the U.S. for six (6) consecutive months.
- **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 22, Section P for all applicants including spouse/domestic partner (DP) and children age 18 and over.**
- Underwritten by Aetna Life Insurance Company.
- 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.

A. Applicant Information

Name

Mailing Address (All Aetna correspondence will be sent to this address) – Include Apartment Number, if applicable.	Billing Address (if you prefer your bill to be mailed to a different address than listed above.) – Include Apartment Number, if applicable.
Number, Street ____	Number, Street ____
County ____	City, State, ZIP Code ____
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

Choose desired benefit plan type:	Reason for Application:
Managed Choice Open Access: ☐ 1750 ☐ 2750 ☐ 3500 ☐ 5000	☐ New Enrollment for Aetna Advantage Plans
Managed Choice Open Access Value: ☐ 2500 ☐ 5000 ☐ 8000	☐ Add Spouse/Domestic Partner/Dependent Child to an Existing Plan
☐ High Deductible 3500 (HSA Compatible)	☐ Add Dependent Child To An Existing Plan
☐ High Deductible 5500 (HSA Compatible)	☐ Change Existing Benefit Plan (Existing Advantage Plan Member Only)
☐ Preventive and Hospital Care 2750 (HSA Compatible)	☐ Request for Rate Review
☐ MCOA 7500 with Unlimited Primary Care Visits plus Dental	
☐ Dental (Dental option available only with choice of medical plan above.)	

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

***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

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B. Individuals 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	Spouse/Domestic Partner						
01	Dependent						
02	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/domestic partner/children covered also? ☐ 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 an Aetna Plan?
☐ Yes ☐ No If "Yes," provide the following information.

Name(s):	Relationship:	ID No.:
______________	______________	______________
______________	______________	______________

Has any person listed on this application ever been declined, postponed, had a waiver applied or charged an additional premium for life, disability or health insurance?
☐ Yes ☐ No If "Yes," provide the following information.
Name: ______________________
Explanation: ______________________

Has any person listed on this application had their health insurance rescinded?
☐ Yes ☐ No If "Yes," provide the following information.
Name: ______________________
Date: ______________
Explanation: ______________________

Has any person listed on this application 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: ______________________

Are any persons listed above eligible for Medicare?
☐ Yes ☐ No Name:
____
____

Health History

Each applicant must complete a separate Health History section.

You must provide truthful and complete answers to the following questions to the best of your ability. Aetna relies on the information provided to determine if you are eligible for coverage. We have the right to review medical records, pharmacy and claims history to verify the accuracy of your information. Even if you have had prior or have current coverage with Aetna, you must fully answer all the questions.

All questions must be answered or your application will be returned. If you cannot answer a question, provide details or are not sure of a medical term please check "Not Sure". Aetna will contact you and/or your health care providers to assist with your medical history.

Applicant's Social Security Number

Application ID Number

D. Health History for Primary Applicant

Applicant Name

If you answer "Yes" or "Not Sure" on any of the questions below, provide details on Pages 5 and 6.

In the past five (5) years, have you the primary applicant 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	☐ Yes ☐ No ☐ Not Sure
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 ☐ Not Sure
D3.	**Musculoskeletal Conditions/Disorders:** Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as: Strain/sprain, fibromyalgia, gout Fracture, internal/external fixations, permanent hardware, amputation/prosthesis Arthritis, joint replacement, herniated disc, back or neck pain	☐ Yes ☐ No ☐ Not Sure
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 ☐ Not Sure
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 ☐ Not Sure
D6.	**Urinary Conditions/Disorders:** Bladder infections, kidney infections, stones, blood in urine Stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting	☐ Yes ☐ No ☐ Not Sure
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, valve replacement, prolapsed or leaky valve, pacemaker or defibrillator, aneurysm	☐ Yes ☐ No ☐ Not Sure
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 ☐ Not Sure
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 ☐ Not Sure

continued

Applicant's Social Security Number

Application ID Number

D. Health History for Primary Applicant (Continued)

D10.	**Male Reproductive Conditions/Disorders:** a) Fertility/infertility, low sperm count, sexual dysfunction Erectile dysfunction, enlarged prostate, prostatitis, undescended testes Genital or anal herpes/warts, sexually transmitted diseases	☐ Yes ☐ No ☐ Not Sure
	b) Are you 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?	☐ Yes ☐ No ☐ Not Sure
D11.	**Female Reproductive Conditions/Disorders:** a) Pelvic pain, abnormal menstrual bleeding, endometriosis, ovarian cysts, absence of menstruation Abnormal PAP smear, uterine fibroids, fertility/infertility, miscarriage, genital warts/herpes or sexually transmitted diseases Breast cysts/lumps/fibroids, breast implants	☐ Yes ☐ No ☐ Not Sure
	b) Has it been more than 40 days since you had your last menstrual period? If "Yes," check one: ☐ Menopause ☐ Birth Control ☐ Hysterectomy ☐ Other (provide reason): ______	☐ Yes ☐ No ☐ Not Sure
	c) Have you had an abnormal PAP smear? If "Yes," provide details on **Page 5**. Date of last normal PAP smear. Date: ______	☐ Yes ☐ No ☐ Not Sure
	d) Are you currently pregnant, tested positive with a home pregnancy test, or in the process of adoption or using a surrogate?	☐ Yes ☐ No ☐ Not Sure
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 ☐ Not Sure
D13.	**Cancer/Tumors:** Cysts, tumors or abnormal growths Hodgkin's disease, leukemia or any other cancer or malignancy	☐ Yes ☐ No ☐ Not Sure
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 ☐ Not Sure
D15.	In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake?	☐ Yes ☐ No ☐ Not Sure
D16.	In the past 5 years, have you ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: ______ Date Discontinued: ______ ______ ______	☐ Yes ☐ No ☐ Not Sure
D17.	Have you consumed any alcoholic beverage in the past 6 months? (Amount: A drink is 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor.) Type: ______ Amount: per ☐ Day ☐ Week ☐ Month ______ per ☐ Day ☐ Week ☐ Month	☐ Yes ☐ No ☐ Not Sure
D18.	In the past 5 years, have you been convicted of a DUI (drunk driving violation)? If "Yes," provide state(s) and date(s). Name: ______ State: ______ Date: ______ ______ ______ ______	☐ Yes ☐ No ☐ Not Sure
D19.	In the past 5 years, have you been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), or ARC (Aids Related Complex)?	☐ Yes ☐ No ☐ Not Sure
D20.	In the past five (5) years, have you 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 ☐ Not Sure
D21.	In the past 5 years, have you been medically advised to undergo further medical testing, treatment or surgery which has not yet been completed?	☐ Yes ☐ No ☐ Not Sure

continued

Applicant's Social Security Number

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D. Health History for Primary Applicant (Continued)

D22.	In the past 5 years, have you been a patient in an outpatient clinic, surgical center, urgent care, treatment center or inpatient in a hospital or other medical facility for any reason other than pregnancy?	☐ Yes ☐ No ☐ Not Sure
D23.	Are you a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	☐ Yes ☐ No ☐ Not Sure
D24.	Are you currently on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	☐ Yes ☐ No ☐ Not Sure
D25.	Have you smoked or used tobacco products, such as snuff and/or chewing tobacco, in the past 12 months? Date Stopped: ____________________	☐ Yes ☐ No ☐ Not Sure
D26.	Have you taken prescription medications or been advised to take prescription medications in the past 2 years?	☐ Yes ☐ No ☐ Not Sure
D27	Within the past two (2) years, have you seen a health care provider (physician, physicians assistant, nurse practitioner, chiropractor, physical therapist or any licensed provider) **not already disclosed on this application**?	☐ Yes ☐ No ☐ Not Sure
D28	Within the past two (2), years have you had any change in your health status, an illness, or injury not mentioned on your application **that you have NOT seen a health care provider for**?	☐ Yes ☐ No ☐ Not Sure

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

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.

Medical History and Treatment History for the Primary Applicant

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

If you have answered "Yes" to any of the questions in Section D, you must provide detailed information below.

Question Number: ________
Name of Condition/Illness: ____________________
Date of Onset/Treatment (mm/yyyy): ____________ Date ended: ____________ ☐ Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): ____________________
Name of Hospital, clinic or Health Care Provider: ____________________
Address: ____________________
City: ____________________ State: ________ ZIP: ____________
Telephone Number: (   ) ____________________

Question Number: ________
Name of Condition/Illness: ____________________
Date of Onset/Treatment (mm/yyyy): ____________ Date ended: ____________ ☐ Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): ____________________
Name of Hospital, clinic or Health Care Provider: ____________________
Address: ____________________
City: ____________________ State: ________ ZIP: ____________
Telephone Number: (   ) ____________________

Question Number: ________
Name of Condition/Illness: ____________________
Date of Onset/Treatment (mm/yyyy): ____________ Date ended: ____________ ☐ Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): ____________________
Name of Hospital, clinic or Health Care Provider: ____________________
Address: ____________________
City: ____________________ State: ________ ZIP: ____________
Telephone Number: (   ) ____________________

continued

Applicant's Social Security Number

Application ID Number

D. Health History for Primary Applicant (Continued)

Medical History and Treatment History for the Primary Applicant

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

If you have answered "Not Sure" to any of the questions in Section D, you must provide detailed information below.

Question Number: ________

Name of Condition/Illness: ____________________

☐ Do not understand the medical terms used

☐ Do not understand the question

☐ Do not know if you have the listed condition

☐ Had or have the listed condition but cannot remember details

Provide any additional information to explain why you answered "Not Sure"

____

Question Number: ________

Name of Condition/Illness: ____________________

☐ Do not understand the medical terms used

☐ Do not understand the question

☐ Do not know if you have the listed condition

☐ Had or have the listed condition but cannot remember details

Provide any additional information to explain why you answered "Not Sure"

____

Question Number: ________

Name of Condition/Illness: ____________________

☐ Do not understand the medical terms used

☐ Do not understand the question

☐ Do not know if you have the listed condition

☐ Had or have the listed condition but cannot remember details

Provide any additional information to explain why you answered "Not Sure"

____

Medication or Pharmacy History for the Primary Applicant

List all medications prescribed and/or taken in the past twelve (12) months

Medication Name (i.e. Ativan)	Frequency and route (i.e. daily/oral)	Condition for which medication was prescribed	Date Prescribed (mm/yyyy)	Date Stopped (mm/yyyy)	Still Taking
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐

Applicant's Social Security Number

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E. Health History for Spouse/Domestic Partner

Spouse/Domestic Partner Name

If you answer "Yes" or "Not Sure" on any of the questions below, provide details on Pages 9 and 10.

In the past five (5) years, have you, (Spouse/Domestic Partner) consulted a health care provider, received treatment (including prescription medications) or been hospitalized for any of the following conditions or diseases?

E1.	**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 ☐ Not Sure
E2.	**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 ☐ Not Sure
E3.	**Musculoskeletal Conditions/Disorders:** Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as: Strain/sprain, fibromyalgia, gout Fracture, internal/external fixations, permanent hardware, amputation/prosthesis Arthritis, joint replacement, herniated disc, back or neck pain	☐ Yes ☐ No ☐ Not Sure
E4.	**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 ☐ Not Sure
E5.	**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 ☐ Not Sure
E6.	**Urinary Conditions/Disorders:** Bladder infections, kidney infections, stones, blood in urine Stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting	☐ Yes ☐ No ☐ Not Sure
E7.	**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, valve replacement, prolapsed or leaky valve, pacemaker or defibrillator, aneurysm	☐ Yes ☐ No ☐ Not Sure
E8.	**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 ☐ Not Sure
E9.	**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 ☐ Not Sure

continued

Applicant's Social Security Number

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E. Health History Health History for Spouse/Domestic Partner (Continued)

E10.	**Male Reproductive Conditions/Disorders:** a) Fertility/infertility, low sperm count, sexual dysfunction Erectile dysfunction, enlarged prostate, prostatitis, undescended testes Genital or anal herpes/warts, sexually transmitted diseases	☐ Yes ☐ No ☐ Not Sure
	b) Are you 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?	☐ Yes ☐ No ☐ Not Sure
E11.	**Female Reproductive Conditions/Disorders:** a) Pelvic pain, abnormal menstrual bleeding, endometriosis, ovarian cysts, absence of menstruation Abnormal PAP smear, uterine fibroids, fertility/infertility, miscarriage, genital warts/herpes or sexually transmitted diseases Breast cysts/lumps/fibroids, breast implants	☐ Yes ☐ No ☐ Not Sure
	b) Has it been more than 40 days since you had your last menstrual period? If "Yes," check one: ☐ Menopause ☐ Birth Control ☐ Hysterectomy ☐ Other (provide reason): ______________________	☐ Yes ☐ No ☐ Not Sure
	c) Have you had an abnormal PAP smear? If "Yes," provide details on **Page 9**. Date of last normal PAP smear. Date: ______________	☐ Yes ☐ No ☐ Not Sure
	d) Are you currently pregnant, tested positive with a home pregnancy test, or in the process of adoption or using a surrogate?	☐ Yes ☐ No ☐ Not Sure
E12.	**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 ☐ Not Sure
E13.	**Cancer/Tumors:** Cysts, tumors or abnormal growths Hodgkin's disease, leukemia or any other cancer or malignancy	☐ Yes ☐ No ☐ Not Sure
E14.	**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 ☐ Not Sure
E15.	In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake?	☐ Yes ☐ No ☐ Not Sure
E16.	In the past 5 years, have you ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: ______________ Date Discontinued: ______________ ______________ ______________	☐ Yes ☐ No ☐ Not Sure
E17.	Have you consumed any alcoholic beverage in the past 6 months? (Amount: A drink is 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor.) Type: ______________ Amount: per ☐ Day ☐ Week ☐ Month ______________ per ☐ Day ☐ Week ☐ Month	☐ Yes ☐ No ☐ Not Sure
E18.	In the past 5 years, have you been convicted of a DUI (drunk driving violation)? If "Yes," provide state(s) and date(s). Name: ______________ State: ________ Date: ________ ______________ ________ ________	☐ Yes ☐ No ☐ Not Sure
E19.	In the past 5 years, have you been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), or ARC (Aids Related Complex)?	☐ Yes ☐ No ☐ Not Sure
E20.	In the past five (5) years, have you 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 ☐ Not Sure
E21.	In the past 5 years, have you been medically advised to undergo further medical testing, treatment or surgery which has not yet been completed?	☐ Yes ☐ No ☐ Not Sure

continued

Applicant's Social Security Number

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E. Health History Health History for Spouse/Domestic Partner (Continued)

E22.	In the past 5 years, have you been a patient in an outpatient clinic, surgical center, urgent care, treatment center or inpatient in a hospital or other medical facility for any reason other than pregnancy?	☐ Yes ☐ No ☐ Not Sure
E23.	Are you a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	☐ Yes ☐ No ☐ Not Sure
E24.	Are you currently on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	☐ Yes ☐ No ☐ Not Sure
E25.	Have you smoked or used tobacco products, such as snuff and/or chewing tobacco, in the past 12 months? Date Stopped: ____________________	☐ Yes ☐ No ☐ Not Sure
E26.	Have you taken prescription medications or been advised to take prescription medications in the past 2 years?	☐ Yes ☐ No ☐ Not Sure
E27	Within the past two (2) years, have you seen a health care provider (physician, physicians assistant, nurse practitioner, chiropractor, physical therapist or any licensed provider) **not already disclosed on this application**?	☐ Yes ☐ No ☐ Not Sure
E28	Within the past two (2), years have you had any change in your health status, an illness, or injury not mentioned on your application **that you have NOT seen a health care provider for**?	☐ Yes ☐ No ☐ Not Sure

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

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.

Medical History and Treatment History for Spouse/Domestic Partner

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

If you have answered "Yes" to any of the questions in Section E, you must provide detailed information below.

Question Number: ________
Name of Condition/Illness: ____________________
Date of Onset/Treatment (mm/yyyy): ____________________ Date ended: ____________________ ☐ Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): ____________________
Name of Hospital, clinic or Health Care Provider: ____________________
Address: ____________________
City: ____________________ State: __________ ZIP: ____________________
Telephone Number: (   ) ____________________

Question Number: ________
Name of Condition/Illness: ____________________
Date of Onset/Treatment (mm/yyyy): ____________________ Date ended: ____________________ ☐ Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): ____________________
Name of Hospital, clinic or Health Care Provider: ____________________
Address: ____________________
City: ____________________ State: __________ ZIP: ____________________
Telephone Number: (   ) ____________________

Question Number: ________
Name of Condition/Illness: ____________________
Date of Onset/Treatment (mm/yyyy): ____________________ Date ended: ____________________ ☐ Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): ____________________
Name of Hospital, clinic or Health Care Provider: ____________________
Address: ____________________
City: ____________________ State: __________ ZIP: ____________________
Telephone Number: (   ) ____________________

continued

Applicant's Social Security Number

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E. Health History for Spouse/Domestic Partner (Continued)

Medical History and Treatment History for the Spouse/Domestic Partner

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

If you have answered "Not Sure" to any of the questions in Section E, you must provide detailed information below.

Question Number: ________

Name of Condition/Illness: ______________________________

☐ Do not understand the medical terms used
☐ Do not understand the question
☐ Do not know if you have the listed condition
☐ Had or have the listed condition but cannot remember details

Provide any additional information to explain why you answered "Not Sure"

____

Question Number: ________

Name of Condition/Illness: ______________________________

☐ Do not understand the medical terms used
☐ Do not understand the question
☐ Do not know if you have the listed condition
☐ Had or have the listed condition but cannot remember details

Provide any additional information to explain why you answered "Not Sure"

____

Question Number: ________

Name of Condition/Illness: ______________________________

☐ Do not understand the medical terms used
☐ Do not understand the question
☐ Do not know if you have the listed condition
☐ Had or have the listed condition but cannot remember details

Provide any additional information to explain why you answered "Not Sure"

____

Medication or Pharmacy History for the Spouse/Domestic Partner

List all medications prescribed and/or taken in the past twelve (12) months

Medication Name (i.e. Ativan)	Frequency and route (i.e. daily/oral)	Condition for which medication was prescribed	Date Prescribed (mm/yyyy)	Date Stopped (mm/yyyy)	Still Taking
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐

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F. Health History for Dependent 01

Dependent 01 Name

If you answer "Yes" or "Not Sure" on any of the questions below, provide details on Pages 13 and 14.

In the past five (5) years, have you, (Dependent 01) consulted 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 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 ☐ Not Sure
F2.	**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 ☐ Not Sure
F3.	**Musculoskeletal Conditions/Disorders:** Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as: Strain/sprain, fibromyalgia, gout Fracture, internal/external fixations, permanent hardware, amputation/prosthesis Arthritis, joint replacement, herniated disc, back or neck pain	☐ Yes ☐ No ☐ Not Sure
F4.	**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 ☐ Not Sure
F5.	**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 ☐ Not Sure
F6.	**Urinary Conditions/Disorders:** Bladder infections, kidney infections, stones, blood in urine Stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting	☐ Yes ☐ No ☐ Not Sure
F7.	**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, valve replacement, prolapsed or leaky valve, pacemaker or defibrillator, aneurysm	☐ Yes ☐ No ☐ Not Sure
F8.	**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 ☐ Not Sure
F9.	**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 ☐ Not Sure

continued

Applicant's Social Security Number

Application ID Number

F. Health History Health History for **Dependent 01** (Continued)

F10.	**Male Reproductive Conditions/Disorders:** a) Fertility/infertility, low sperm count, sexual dysfunction Erectile dysfunction, enlarged prostate, prostatitis, undescended testes Genital or anal herpes/warts, sexually transmitted diseases	☐ Yes ☐ No ☐ Not Sure
	b) Are you 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?	☐ Yes ☐ No ☐ Not Sure
F11.	**Female Reproductive Conditions/Disorders:** a) Pelvic pain, abnormal menstrual bleeding, endometriosis, ovarian cysts, absence of menstruation Abnormal PAP smear, uterine fibroids, fertility/infertility, miscarriage, genital warts/herpes or sexually transmitted diseases Breast cysts/lumps/fibroids, breast implants	☐ Yes ☐ No ☐ Not Sure
	b) Has it been more than 40 days since you had your last menstrual period? If "Yes," check one: ☐ Menopause ☐ Birth Control ☐ Hysterectomy ☐ Other (provide reason): ____________	☐ Yes ☐ No ☐ Not Sure
	c) Have you had an abnormal PAP smear? If "Yes," provide details on **Page 13**. Date of last normal PAP smear. Date: ____________	☐ Yes ☐ No ☐ Not Sure
	d) Are you currently pregnant, tested positive with a home pregnancy test, or in the process of adoption or using a surrogate?	☐ Yes ☐ No ☐ Not Sure
F12.	**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 ☐ Not Sure
F13.	**Cancer/Tumors:** Cysts, tumors or abnormal growths Hodgkin's disease, leukemia or any other cancer or malignancy	☐ Yes ☐ No ☐ Not Sure
F14.	**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 ☐ Not Sure
F15.	In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake?	☐ Yes ☐ No ☐ Not Sure
F16.	In the past 5 years, have you ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: ____________ Date Discontinued: ____________ ____________ ____________	☐ Yes ☐ No ☐ Not Sure
F17.	Have you consumed any alcoholic beverage in the past 6 months? (Amount: A drink is 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor.) Type: ____________ Amount: per ☐ Day ☐ Week ☐ Month ____________ per ☐ Day ☐ Week ☐ Month	☐ Yes ☐ No ☐ Not Sure
F18.	In the past 5 years, have you been convicted of a DUI (drunk driving violation)? If "Yes," provide state(s) and date(s). Name: ____________ State: ______ Date: ______ ____________ ______ ______	☐ Yes ☐ No ☐ Not Sure
F19.	In the past 5 years, have you been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), or ARC (Aids Related Complex)?	☐ Yes ☐ No ☐ Not Sure
F20.	In the past five (5) years, have you 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 ☐ Not Sure
F21.	In the past 5 years, have you been medically advised to undergo further medical testing, treatment or surgery which has not yet been completed?	☐ Yes ☐ No ☐ Not Sure

continued

Applicant's Social Security Number

Application ID Number

F. Health History Health History for Dependent 01 (Continued)

F22.	In the past 5 years, have you been a patient in an outpatient clinic, surgical center, urgent care, treatment center or inpatient in a hospital or other medical facility for any reason other than pregnancy?	☐ Yes ☐ No ☐ Not Sure
F23.	Are you a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	☐ Yes ☐ No ☐ Not Sure
F24.	Are you on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	☐ Yes ☐ No ☐ Not Sure
F25.	Have you or used tobacco products, such as snuff and/or chewing tobacco, in the past 12 months? Date Stopped: ____________________	☐ Yes ☐ No ☐ Not Sure
F26.	Have you taken prescription medications or been advised to take prescription medications in the past 2 years?	☐ Yes ☐ No ☐ Not Sure
F27	Within the past two (2) years, have you seen a health care provider (physician, physicians assistant, nurse practitioner, chiropractor, physical therapist or any licensed provider) **not already disclosed on this application**?	☐ Yes ☐ No ☐ Not Sure
F28	Within the past two (2), years have you had any change in your health status, an illness, or injury not mentioned on your application **that you have NOT seen a health care provider for**?	☐ Yes ☐ No ☐ Not Sure

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

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.

Medical History and Treatment History for Dependent 01

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

If you have answered "Yes" to any of the questions in Section F, you must provide detailed information below.

Question Number: ________
Name of Condition/Illness: ____________________
Date of Onset/Treatment (mm/yyyy): ____________________ Date ended: ____________________ ☐ Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): ____________________
Name of Hospital, clinic or Health Care Provider: ____________________
Address: ____________________
City: ____________________ State: __________ ZIP: ____________________
Telephone Number: ( ) ____________________

Question Number: ________
Name of Condition/Illness: ____________________
Date of Onset/Treatment (mm/yyyy): ____________________ Date ended: ____________________ ☐ Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): ____________________
Name of Hospital, clinic or Health Care Provider: ____________________
Address: ____________________
City: ____________________ State: __________ ZIP: ____________________
Telephone Number: ( ) ____________________

Question Number: ________
Name of Condition/Illness: ____________________
Date of Onset/Treatment (mm/yyyy): ____________________ Date ended: ____________________ ☐ Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): ____________________
Name of Hospital, clinic or Health Care Provider: ____________________
Address: ____________________
City: ____________________ State: __________ ZIP: ____________________
Telephone Number: ( ) ____________________

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F. Health History for Dependent 01 (Continued)
Medical History and Treatment History for Dependent 01
☐ ***Check here if more space is needed. Use a separate sheet of paper and staple to the back of this application.***

If you have answered "Not Sure" to any of the questions in Section F, you must provide detailed information below.

Question Number: ________
Name of Condition/Illness: ______________________________
☐ Do not understand the medical terms used
☐ Do not understand the question
☐ Do not know if you have the listed condition
☐ Had or have the listed condition but cannot remember details
Provide any additional information to explain why you answered "Not Sure"
____

Question Number: ________
Name of Condition/Illness: ______________________________
☐ Do not understand the medical terms used
☐ Do not understand the question
☐ Do not know if you have the listed condition
☐ Had or have the listed condition but cannot remember details
Provide any additional information to explain why you answered "Not Sure"
____

Question Number: ________
Name of Condition/Illness: ______________________________
☐ Do not understand the medical terms used
☐ Do not understand the question
☐ Do not know if you have the listed condition
☐ Had or have the listed condition but cannot remember details
Provide any additional information to explain why you answered "Not Sure"
____

Medication or Pharmacy History for Dependent 01
List all medications prescribed and/or taken in the past twelve (12) months

Medication Name (i.e. Ativan)	Frequency and route (i.e. daily/oral)	Condition for which medication was prescribed	Date Prescribed (mm/yyyy)	Date Stopped (mm/yyyy)	Still Taking
					☐
					☐
					☐
					☐
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					☐

Applicant's Social Security Number

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G. Health History for Dependent 02

Dependent 02 Name

If you answer "Yes" or "Not Sure" on any of the questions below, provide details on Pages 17 and 18.		
In the past five (5) years, have you, (Dependent 02) consulted a health care provider, received treatment (including prescription medications) or been hospitalized for any of the following conditions or diseases?		
G1.	**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 ☐ Not Sure
G2.	**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 ☐ Not Sure
G3.	**Musculoskeletal Conditions/Disorders:** Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as: Strain/sprain, fibromyalgia, gout Fracture, internal/external fixations, permanent hardware, amputation/prosthesis Arthritis, joint replacement, herniated disc, back or neck pain	☐ Yes ☐ No ☐ Not Sure
G4.	**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 ☐ Not Sure
G5.	**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 ☐ Not Sure
G6.	**Urinary Conditions/Disorders:** Bladder infections, kidney infections, stones, blood in urine Stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting	☐ Yes ☐ No ☐ Not Sure
G7.	**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, valve replacement, prolapsed or leaky valve, pacemaker or defibrillator, aneurysm	☐ Yes ☐ No ☐ Not Sure
G8.	**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 ☐ Not Sure
G9.	**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 ☐ Not Sure

continued

Applicant's Social Security Number

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G. Health History Health History for Dependent 02 (Continued)

G10.	**Male Reproductive Conditions/Disorders:** a) Fertility/infertility, low sperm count, sexual dysfunction Erectile dysfunction, enlarged prostate, prostatitis, undescended testes Genital or anal herpes/warts, sexually transmitted diseases	☐ Yes ☐ No ☐ Not Sure
	b) Are you 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?	☐ Yes ☐ No ☐ Not Sure
G11.	**Female Reproductive Conditions/Disorders:** a) Pelvic pain, abnormal menstrual bleeding, endometriosis, ovarian cysts, absence of menstruation Abnormal PAP smear, uterine fibroids, fertility/infertility, miscarriage, genital warts/herpes or sexually transmitted diseases Breast cysts/lumps/fibroids, breast implants	☐ Yes ☐ No ☐ Not Sure
	b) Has it been more than 40 days since you had your last menstrual period? If "Yes," check one: ☐ Menopause ☐ Birth Control ☐ Hysterectomy ☐ Other (provide reason): ______	☐ Yes ☐ No ☐ Not Sure
	c) Have you had an abnormal PAP smear? If "Yes," provide details on **Page 17**. Date of last normal PAP smear. Date: ______	☐ Yes ☐ No ☐ Not Sure
	d) Are you currently pregnant, tested positive with a home pregnancy test, or in the process of adoption or using a surrogate?	☐ Yes ☐ No ☐ Not Sure
G12.	**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 ☐ Not Sure
G13.	**Cancer/Tumors:** Cysts, tumors or abnormal growths Hodgkin's disease, leukemia or any other cancer or malignancy	☐ Yes ☐ No ☐ Not Sure
G14.	**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 ☐ Not Sure
G15.	In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake?	☐ Yes ☐ No ☐ Not Sure
G16.	In the past 5 years, have you ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: ______ Date Discontinued: ______ ______ ______	☐ Yes ☐ No ☐ Not Sure
G17.	Have you consumed any alcoholic beverage in the past 6 months? (Amount: A drink is 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor.) Type: ______ Amount: per ☐ Day ☐ Week ☐ Month ______ per ☐ Day ☐ Week ☐ Month	☐ Yes ☐ No ☐ Not Sure
G18.	In the past 5 years, have you been convicted of a DUI (drunk driving violation)? If "Yes," provide state(s) and date(s). Name: ______ State: ______ Date: ______ ______ ______ ______	☐ Yes ☐ No ☐ Not Sure
G19.	In the past 5 years, have you been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), or ARC (Aids Related Complex)?	☐ Yes ☐ No ☐ Not Sure
G20.	In the past five (5) years, have you 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 ☐ Not Sure
G21.	In the past 5 years, have you been medically advised to undergo further medical testing, treatment or surgery which has not yet been completed?	☐ Yes ☐ No ☐ Not Sure

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Applicant's Social Security Number

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G. Health History Health History for Dependent 02 (Continued)

G22.	In the past 5 years, have you been a patient in an outpatient clinic, surgical center, urgent care, treatment center or inpatient in a hospital or other medical facility for any reason other than pregnancy?	☐ Yes ☐ No ☐ Not Sure
G23.	Are you a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	☐ Yes ☐ No ☐ Not Sure
G24.	Are you on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	☐ Yes ☐ No ☐ Not Sure
G25.	Have you smoked or used tobacco products, such as snuff and/or chewing tobacco, in the past 12 months? Date Stopped: ____________	☐ Yes ☐ No ☐ Not Sure
G26.	Have you taken prescription medications or been advised to take prescription medications in the past 2 years?	☐ Yes ☐ No ☐ Not Sure
G27	Within the past two (2) years, have you seen a health care provider (physician, physicians assistant, nurse practitioner, chiropractor, physical therapist or any licensed provider) **not already disclosed on this application**?	☐ Yes ☐ No ☐ Not Sure
G28	Within the past two (2), years have you had any change in your health status, an illness, or injury not mentioned on your application **that you have NOT seen a health care provider for**?	☐ Yes ☐ No ☐ Not Sure

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

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.

Medical History and Treatment History for Dependent 02

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

If you have answered "Yes" to any of the questions in Section G, you must provide detailed information below.

Question Number: ________
Name of Condition/Illness: ________________
Date of Onset/Treatment (mm/yyyy): ____________ Date ended: ____________ ☐ Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): ________________
Name of Hospital, clinic or Health Care Provider: ________________
Address: ________________
City: ________________ State: ________ ZIP: ____________
Telephone Number: (   ) ________________

Question Number: ________
Name of Condition/Illness: ________________
Date of Onset/Treatment (mm/yyyy): ____________ Date ended: ____________ ☐ Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): ________________
Name of Hospital, clinic or Health Care Provider: ________________
Address: ________________
City: ________________ State: ________ ZIP: ____________
Telephone Number: (   ) ________________

Question Number: ________
Name of Condition/Illness: ________________
Date of Onset/Treatment (mm/yyyy): ____________ Date ended: ____________ ☐ Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): ________________
Name of Hospital, clinic or Health Care Provider: ________________
Address: ________________
City: ________________ State: ________ ZIP: ____________
Telephone Number: (   ) ________________

continued

Applicant's Social Security Number

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G. Health History for Dependent 02 (Continued)

Medical History and Treatment History for Dependent 02

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

If you have answered "Not Sure" to any of the questions in Section G, you must provide detailed information below.

Question Number: ________

Name of Condition/Illness: ________________________________

☐ Do not understand the medical terms used
☐ Do not understand the question
☐ Do not know if you have the listed condition
☐ Had or have the listed condition but cannot remember details

Provide any additional information to explain why you answered "Not Sure"

____

Question Number: ________

Name of Condition/Illness: ________________________________

☐ Do not understand the medical terms used
☐ Do not understand the question
☐ Do not know if you have the listed condition
☐ Had or have the listed condition but cannot remember details

Provide any additional information to explain why you answered "Not Sure"

____

Question Number: ________

Name of Condition/Illness: ________________________________

☐ Do not understand the medical terms used
☐ Do not understand the question
☐ Do not know if you have the listed condition
☐ Had or have the listed condition but cannot remember details

Provide any additional information to explain why you answered "Not Sure"

____

Medication or Pharmacy History for Dependent 02

List all medications prescribed and/or taken in the past twelve (12) months

Medication Name (i.e. Ativan)	Frequency and route (i.e. daily/oral)	Condition for which medication was prescribed	Date Prescribed (mm/yyyy)	Date Stopped (mm/yyyy)	Still Taking
					☐
					☐
					☐
					☐
					☐
					☐
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					☐

Applicant's Social Security Number

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H. 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).
If your requested effective date is prior to your application approval date, Aetna will assign the next available effective date.

I. 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.

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

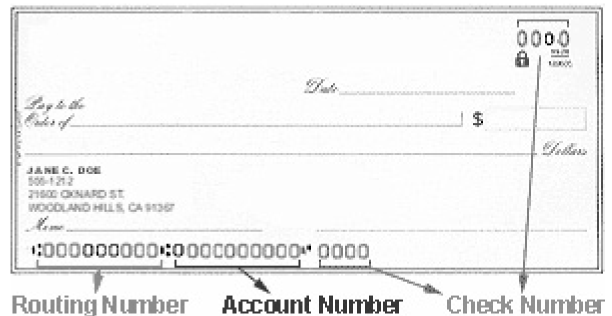
Easy Pay (Electronic Fund Transfer - EFT)

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 "Easy Pay" above and with my application signature on **Page 22, Section P**, 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 <u>0% to 100% of the standard premium</u>.
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 22, Section P**) 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. Please be advised that such rate adjustment may result in an increase of **<u>0% to 100% of the standard premium.</u>**

Applicant's Social Security Number

Application ID Number

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 O** to the applicant.

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

Print Name: ______________________

Street Address: ______________________

City, Zip Code, State: ______________________ Phone Number: ______________________

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

	General Agent	**Insurance Broker**
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: **If you willfully state as true any material fact you know to be false, you shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to $10,000.**	☐ 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

Signature of Insurance Producer (Required)		**Signature of General Agent** (Required, if applicable)	
Date	E-mail Address	Date	E-mail Address
Name of Insurance Producer or Agency to be assigned as Broker of Record (print name)		Name of General Agent (print name)	
TIN Insurance Producer or Agency to be assigned as Broker of Record		Agent TIN Number	
Street Address (Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)		Street Address (Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)	
Telephone Number ( )	Fax Number ( )	Telephone Number ( )	Fax Number ( )

M. Aetna Sales Representative

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

Applicant's Social Security Number

Application ID Number

N. Instructions

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.**

O. 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, 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.
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 the term of the coverage and so long thereafter as allowed by law. 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, as is any authorized representative that I may designate, to receive a copy of this authorization 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. **Attention California Residents: For your protection,** California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison

Applicant's Social Security Number

Application ID Number

P. 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.

I understand that 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.

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 and/or mistake in such information 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 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) will be grounds for termination/cancellation of the coverage for the newborn or adopted child/children listed above and all claims incurred will become the financial responsibility of the undersigned member.

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

Q. Contact Information

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

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

Fax #: 866-892-8396
www.aetna.com/members/individuals

R. DMHC Written Notice of Availability of Language Assistance

HMO and DMO-based plans - **IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-877-287-0117.

Planes basados en DMO y HMO - **IMPORTANTE:** ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

Applicant's Social Security Number

Application ID Number

S. Traditional Plans

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-877-287-0117. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-877-287-0117. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-877-287-0117 與我們聯絡。欲取得其他協助，請致電1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-877-287-0117 . Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-877-287-0117번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-877-287-0117. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգմանիչ ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-877-287-0117 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-877-287-0117. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-877-287-0117までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-877-287-0117 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-877-287-0117 'ਤ ਸਾਨ ਫ਼ਨ ਕਰੋ। ਵਧੇਰ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-877-287-0117 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-877-287-0117 . للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357.Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-877-287-0117. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

CDI Notice of Language Assistance-Trad

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

Applicant's Social Security Number

Application ID Number

Additional Dependent Children (*Dependent children are covered up to age 26.)*

Please complete for each additional dependent and s*taple to the back of the 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)

Health History

Each applicant must complete a separate Health History section.

You must provide truthful and complete answers to the following questions to the best of your ability. Aetna relies on the information provided to determine if you are eligible for coverage. We have the right to review medical records, pharmacy and claims history to verify the accuracy of your information. Even if you have had prior or have current coverage with Aetna, you must fully answer all the questions.

All questions must be answered or your application will be returned. If you cannot answer a question, provide details or are not sure of a medical term please check "Not Sure". Aetna will contact you and/or your health care providers to assist with your medical history.

If you answer "Yes" or "Not Sure" on any of the questions below, provide details on Pages 4 and 5.

In the past five (5) years, have you, (Dependent) consulted a health care provider, received treatment (including prescription medications) or been hospitalized for any of the following conditions or diseases?

HH1.	**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 ☐ Not Sure
HH2.	**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 ☐ Not Sure
HH3.	**Musculoskeletal Conditions/Disorders:** Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as: Strain/sprain, fibromyalgia, gout Fracture, internal/external fixations, permanent hardware, amputation/prosthesis Arthritis, joint replacement, herniated disc, back or neck pain	☐ Yes ☐ No ☐ Not Sure
HH4.	**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 ☐ Not Sure
HH5.	**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 ☐ Not Sure
HH6.	**Urinary Conditions/Disorders:** Bladder infections, kidney infections, stones, blood in urine Stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting	☐ Yes ☐ No ☐ Not Sure
HH7.	**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, valve replacement, prolapsed or leaky valve, pacemaker or defibrillator, aneurysm	☐ Yes ☐ No ☐ Not Sure

continued

Applicant's Social Security Number

Application ID Number

Health History for Additional Dependent (Continued)

HH8.	**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 ☐ Not Sure
HH9.	**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 ☐ Not Sure
HH10.	**Male Reproductive Conditions/Disorders:** a) Fertility/infertility, low sperm count, sexual dysfunction Erectile dysfunction, enlarged prostate, prostatitis, undescended testes Genital or anal herpes/warts, sexually transmitted diseases	☐ Yes ☐ No ☐ Not Sure
	b) Are you 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?	☐ Yes ☐ No ☐ Not Sure
HH11.	**Female Reproductive Conditions/Disorders:** a) Pelvic pain, abnormal menstrual bleeding, endometriosis, ovarian cysts, absence of menstruation Abnormal PAP smear**,** uterine fibroids, fertility/infertility, miscarriage, genital warts/herpes or sexually transmitted diseases Breast cysts/lumps/fibroids, breast implants	☐ Yes ☐ No ☐ Not Sure
	b) Has it been more than 40 days since you had your last menstrual period? If "Yes," check one: ☐ Menopause ☐ Birth Control ☐ Hysterectomy ☐ Other (provide reason): ______	☐ Yes ☐ No ☐ Not Sure
	c) Have you had an abnormal PAP smear? If "Yes," provide details on **Page 4**. Date of last normal PAP smear. Date: ______	☐ Yes ☐ No ☐ Not Sure
	d) Are you currently pregnant, tested positive with a home pregnancy test, or in the process of adoption or using a surrogate?	☐ Yes ☐ No ☐ Not Sure
HH12.	**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 ☐ Not Sure
HH13.	**Cancer/Tumors:** Cysts, tumors or abnormal growths Hodgkin's disease, leukemia or any other cancer or malignancy	☐ Yes ☐ No ☐ Not Sure
HH14.	**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 ☐ Not Sure
HH15.	In the past 5 years, have you been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake?	☐ Yes ☐ No ☐ Not Sure
HH16.	In the past 5 years, have you ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal, or controlled IV drugs? Type of Drug/Substance: ______ Date Discontinued: ______ ______ ______	☐ Yes ☐ No ☐ Not Sure
HH17.	Have you consumed any alcoholic beverage in the past 6 months? (Amount: A drink is 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor.) Type: ______ Amount: per ☐ Day ☐ Week ☐ Month ______ per ☐ Day ☐ Week ☐ Month	☐ Yes ☐ No ☐ Not Sure

continued

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Health History for Additional Dependent (Continued)

HH18.	In the past 5 years, have you been convicted of a DUI (drunk driving violation)? If "Yes," provide state(s) and date(s). Name: State: Date:	☐ Yes ☐ No ☐ Not Sure
HH19.	In the past 5 years, have you been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), or ARC (Aids Related Complex)?	☐ Yes ☐ No ☐ Not Sure
HH20.	In the past five (5) years, have you 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 ☐ Not Sure
HH21.	In the past 5 years, have you been medically advised to undergo further medical testing, treatment or surgery which has not yet been completed?	☐ Yes ☐ No ☐ Not Sure
HH22.	In the past 5 years, have you been a patient in an outpatient clinic, surgical center, urgent care, treatment center or inpatient in a hospital or other medical facility for any reason other than pregnancy?	☐ Yes ☐ No ☐ Not Sure
HH23.	Are you a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	☐ Yes ☐ No ☐ Not Sure
HH24.	Are you on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	☐ Yes ☐ No ☐ Not Sure
HH25.	Have you or used tobacco products, such as snuff and/or chewing tobacco, in the past 12 months? Date Stopped: ____________________	☐ Yes ☐ No ☐ Not Sure
HH26.	Have you taken prescription medications or been advised to take prescription medications in the past 2 years?	☐ Yes ☐ No ☐ Not Sure
HH27.	Within the past two (2) years, have you seen a health care provider (physician, physicians assistant, nurse practitioner, chiropractor, physical therapist or any licensed provider) **not already disclosed on this application**?	☐ Yes ☐ No ☐ Not Sure
HH28.	Within the past two (2), years have you had any change in your health status, an illness, or injury not mentioned on your application **that you have NOT seen a health care provider for**?	☐ Yes ☐ No ☐ Not Sure

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

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

Medical History and Treatment History for Additional Dependent

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

If you have answered "Yes" to any of the questions in Section HH, you must provide detailed information below.

Question Number: ________
Name of Condition/Illness: ________
Date of Onset/Treatment (mm/yyyy): ________ Date ended: ________ ☐ Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): ________
Name of Hospital, clinic or Health Care Provider: ________
Address: ________
City: ________ State: ________ ZIP: ________
Telephone Number: (   ) ________

Question Number: ________
Name of Condition/Illness: ________
Date of Onset/Treatment (mm/yyyy): ________ Date ended: ________ ☐ Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): ________
Name of Hospital, clinic or Health Care Provider: ________
Address: ________
City: ________ State: ________ ZIP: ________
Telephone Number: (   ) ________

Question Number: ________
Name of Condition/Illness: ________
Date of Onset/Treatment (mm/yyyy): ________ Date ended: ________ ☐ Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): ________
Name of Hospital, clinic or Health Care Provider: ________
Address: ________
City: ________ State: ________ ZIP: ________
Telephone Number: (   ) ________

Question Number: ________
Name of Condition/Illness: ________
Date of Onset/Treatment (mm/yyyy): ________ Date ended: ________ ☐ Still under treatment
Treatment(X-ray, Labs, surgical procedure, therapy): ________
Name of Hospital, clinic or Health Care Provider: ________
Address: ________
City: ________ State: ________ ZIP: ________
Telephone Number: (   ) ________

continued

Applicant's Social Security Number

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Medical History and Treatment History for Additional Dependent (Continued)

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

If you have answered "Not Sure" to any of the questions in Section HH, you must provide detailed information below.

Question Number: ________

Name of Condition/Illness: ________________

☐ Do not understand the medical terms used
☐ Do not understand the question
☐ Do not know if you have the listed condition
☐ Had or have the listed condition but cannot remember details

Provide any additional information to explain why you answered "Not Sure"

____

Question Number: ________

Name of Condition/Illness: ________________

☐ Do not understand the medical terms used
☐ Do not understand the question
☐ Do not know if you have the listed condition
☐ Had or have the listed condition but cannot remember details

Provide any additional information to explain why you answered "Not Sure"

____

Question Number: ________

Name of Condition/Illness: ________________

☐ Do not understand the medical terms used
☐ Do not understand the question
☐ Do not know if you have the listed condition
☐ Had or have the listed condition but cannot remember details

Provide any additional information to explain why you answered "Not Sure"

____

Question Number: ________

Name of Condition/Illness: ________________

☐ Do not understand the medical terms used
☐ Do not understand the question
☐ Do not know if you have the listed condition
☐ Had or have the listed condition but cannot remember details

Provide any additional information to explain why you answered "Not Sure"

____

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Medication or Pharmacy History for Additional Dependent

List all medications prescribed and/or taken in the past twelve (12) months

Medication Name (i.e. Ativan)	Frequency and route (i.e. daily/oral)	Condition for which medication was prescribed	Date Prescribed (mm/yyyy)	Date Stopped (mm/yyyy)	Still Taking
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐