

Applicant's Social Security Number								

Enrollment Form ID Number								

M. Important Applicant Information Please Read Carefully

- Coverage may be declined, or a premium adjustment made, based on information provided to Aetna during the enrollment process. In the case of denial, you will receive a letter notifying you that your enrollment has not been accepted. Specific details will be kept confidential. If all members on the enrollment form are denied coverage, the original check will be returned directly to the Applicant.
- Do **not** cancel other coverage presently in force until written notification is received from Aetna indicating that your enrollment has been approved and you and covered dependents are in receipt of your member ID card(s) providing the effective date of coverage.

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

N. Initial Payment

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

O. Recurring or Subsequent Payment

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

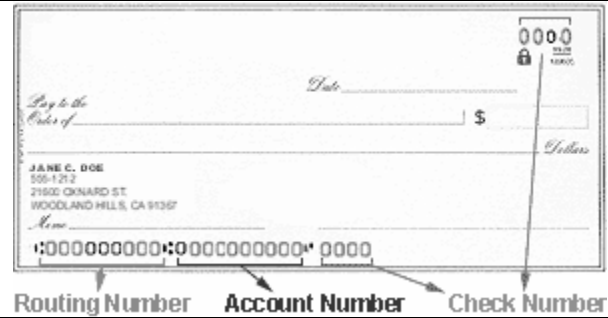
Easy Pay (Electronic Fund Transfer- EFT)

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 enrollment form signature on **Page 5, Section L**, 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 enrollment form. Please be advised that such rate adjustment may result in an increase of 0% to 100% of the standard premium.

NOTE: Aetna reserves the right to refuse/terminate electronic payment services at any time. This agreement remains in effect until Aetna/member terminates it. Joint accounts require the signature of ALL account authorized persons (**Page 5, Section L**) even if not applying.

Credit Card Payment Option

Credit Card Type <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard	Cardholder's Name (exactly as it appears on the card)
Account Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Card Expiration Date

Credit card payment is for your initial premium payment only and will be charged upon approval of your enrollment form. 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.**

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

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

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

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

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

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Q. Insurance Producer Information (If applicable)

1. Are you aware of any information not disclosed on this enrollment form relating to the health, habits or reputation of any person listed on this enrollment form which might have a bearing on the risk? If Yes, please attach explanation.		General Agent <input type="checkbox"/> Yes <input type="checkbox"/> No		Insurance Broker <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Did you see the proposed applicant at the time this application was executed? If No, please explain:		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Signature of Insurance Producer (Required if applicable)			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 of Producer or Agency to be assigned as Broker of Record			Agent TIN Number		
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)			Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)		
Telephone Number ()	Fax Number ()		Telephone Number ()	Fax Number ()	

R. Aetna Sales Representative

Last Name of Sales Representative (print name)	First Name of Sales Representative (print name)
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S. Instructions

Please review these instructions.

- The Applicant must complete the enrollment form. **You are responsible to ensure that the information on the enrollment form is correct, complete, and truthful.**
 - Print clearly using blue or black ink. No pencil or correction fluid, please.
 - This enrollment form must be received by Aetna's Medical Underwriting team within thirty (30) days from the signature date.
 - Any misrepresentation of information on the enrollment form may result in cancellation of coverage.
 - Your insurance will become effective only if this enrollment form is approved as enrolled for and the appropriate premium is enclosed.
You are ineligible for coverage if as a non-citizen Applicant you have not resided in the U.S. for the last six (6) consecutive months.
- Coverage is not guaranteed until approved in writing by Aetna. Do not cancel your current insurance coverage until you have been notified of approval by Aetna and your Aetna coverage is effective.**

T. Effective Date

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

To avoid delays in underwriting, please review for:

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

U. Payment Options

Carefully read the instructions accompanying each payment option (Page 6, Sections N and O).

V. Contact Information

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