Aetna Medicare

Aetna Individual Medicare Supplement Plan Application
Aetna Life Insurance Company
PO Box 13547, Pensacola, FL 32591-3547

INSTRUCTIONS:
To be considered complete, all sections on this form must be filled out, unless marked optional. Please sign and date the form and make a copy for your records. **Incomplete forms could delay processing your enrollment.** For information call **1-800-557-5078**; TTY/TDD (Hearing Impaired) **1-888-200-6124.**

PLEASE READ THE FOLLOWING CONSUMER PROTECTION INFORMATION:

You do not need more than one Medicare Supplement policy.

If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

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1 APPLICANT INFORMATION (Proposed Policyholder) –
Please Print

Last Name	First Name	MI

Social Security Number	☐ Male ☐ Female	Birth Date *(MM/DD/YYYY)*

Street Address (Number, Street, Apt.)

City	State	Zip Code	County

Billing Name (if different from above)

Billing Address (if different from above)

Telephone Number ( )	Primary Language Spoken (optional)

E-mail Address (optional)

2 MEDICARE INFORMATION –
Please fill out this information exactly as it appears on your Medicare card.

MEDICARE ● HEALTH INSURANCE

CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER

_____ – _____ – _____

IS ENTITLED	EFFECTIVE DATE
HOSPITAL (PART A)	
MEDICAL (PART B)	

3 "NOTICE OF POLICY LAPSE" ADDRESSEE INFORMATION – In addition to the policyholder, a copy of any notification of possible policy lapse will be sent to the person listed below. (Please note that **this person should not reside at the same address as the policyholder**.) Name: _____
Address: _____

4 MEDICAL AND GENERAL (A telephone interview with the applicant may be conducted to verify application)
If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.**

Please Mark **Yes** or **No** with an "X"
To the best of your knowledge,

(1) Did you turn age 65 in the last 6-months? ☐ Yes ☐ No
  (a) Did you enroll in Medicare Part B in the last 6-months? ☐ Yes ☐ No
  (b) **IF YES**, what is the effective date? _____
  (c) If you are under age 65, have you been diagnosed with or treated for End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No
(2) Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No
  (**NOTE TO APPLICANT:** Please answer **NO** to this question if you are participating in a "Spend-Down Program" and have not met your "Share of Cost.")
  IF YES,
  (a) Will Medicaid pay your premiums for this Medicare supplement policy? ☐ Yes ☐ No
  (b) Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium? ☐ Yes ☐ No

continued

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Applicant's Name	Social Security Number

4 MEDICAL AND GENERAL (Continued)

(3) If you had coverage from any Medicare plan other than the original Medicare plan within the last 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
START ____/____/____ END ____/____/____

(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ☐ Yes ☐ No

(b) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No

(c) Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐ Yes ☐ No

(4) Do you have another Medicare supplement policy in force? ☐ Yes ☐ No

IF YES,

(a) With what company and what plan do you have?

_____

_____

(b) Do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No

(5) Have you had coverage under any other health insurance plan within the past 63 days? (for example, an employer, union or individual plan) ☐ Yes ☐ No

IF YES,

(a) With what company and what kind of policy?

_____

_____

(b) What are your dates of coverage under the policy? (if you are still covered under the other policy, leave "END" blank).
START ____/____/____ END ____/____/____

5 GUARANTEED ISSUE OR OPEN ENROLLMENT

Please refer to the Guaranteed Issue Guidelines furnished with the Outline of Coverage. If you are applying during open enrollment or if you are eligible for guaranteed issue, please indicate which open enrollment or guaranteed issue provision applies to you with respect to this Medicare supplement application: _____.

Please attach a copy of your termination notice, HIPAA certificate or other correspondence to validate your eligibility for open enrollment or guaranteed issue.

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Applicant's Name	Social Security Number

6 STATEMENT OF HEALTH QUESTIONS (Please answer the following questions to the best of your knowledge.)
Please note: If you are applying during open enrollment or you are eligible for guaranteed issue, you are not required to answer the following health questions.

6a	Are you currently hospitalized, bedridden, confined to a nursing facility, confined to a wheelchair, receiving home health care in the past 90 days; or has any such care been medically advised by a licensed medical practitioner?	☐ Yes ☐ No
6b	**In the past two (2) years,** have you tested positive for exposure to the HIV infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?	☐ Yes ☐ No
6c	**In the past two (2) years,** have you consulted a physician, licensed medical provider, been diagnosed, treated or advised to have treatment for Alzheimer's Disease, Senile Dementia, Organic Brain Disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS), Parkinson's Disease, Muscular Dystrophy or paralysis?	☐ Yes ☐ No
6d	**In the past two (2) years,** have you consulted a physician, licensed medical provider, been diagnosed, treated or advised to have treatment for Diabetes requiring the use of Insulin, kidney failure, kidney dialysis, received an organ transplant or awaiting an organ transplant?	☐ Yes ☐ No
6e	**In the past two (2) years,** have you consulted a physician, licensed medical provider, been diagnosed, treated or advised to have treatment for:	
	1) Congestive Heart Failure, Heart Attack, Angina (chest pain), Coronary Artery Disease, Cardiomyopathy, Stroke (CVA), Transient Ischemic Attack (TIA), Heart Rhythm Disorders requiring pacemaker or defibrillator?	☐ Yes ☐ No
	2) Heart or circulatory surgery of any type including Angioplasty, Bypass, Stent Placement or a Valve Replacement?	☐ Yes ☐ No
	3) Cancer (except skin cancer), Melanoma, Hodgkin's Disease, Leukemia or Multiple Myeloma?	☐ Yes ☐ No
	4) Mental or Nervous Disorder requiring Psychiatric care, Alcohol or Drug Abuse (prescription or non-prescription), Cirrhosis of the Liver or Hepatitis C?	☐ Yes ☐ No
	5) Disabling/Crippling Arthritis, Osteoporosis with compression fractures, Degenerative Bone Disease, Systemic Lupus, or any other Connective Tissue Disease?	☐ Yes ☐ No
	6) Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other Lung Disease, or require the use of oxygen therapy to assist in breathing?	☐ Yes ☐ No
6f	Have you been hospitalized two or more times within the past 24 months (2 years)?	☐ Yes ☐ No
6g	Have you been advised by a licensed medical provider to have surgery, medical tests or treatment that has not been performed or have had medical test(s) for which you have not received the results?	☐ Yes ☐ No
6h	Have you taken any prescription medications within the past 12 months (1 year)? If **YES**, provide details below (attach a separate sheet if necessary):	☐ Yes ☐ No

Medication	**Dosage**	**Medication**	**Dosage**

6i	Have you smoked or used any tobacco product within the past two (2) years?	☐ Yes ☐ No
6j	**List current height** _____ **List current weight** _____	

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Applicant's Name	Social Security Number

7 PLAN SELECTION AND PREMIUM PERIOD OPTIONS

a. Select the Medicare Supplement Plan you are applying for: (choose one)

☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan F ☐ Plan G ☐ Plan N

b. Select your Premium Period: (choose one) - This is the frequency at which you want to pay your premiums.

☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

c. Monthly Premium Rate $ _____ * (The monthly premium rate can be found in the Outline of Coverage.)

***If your current enrollment status required you to complete the Statement of Health Questions in Section 6 and you are a smoker, you will need to adjust your Monthly Premium Rate as follows:**

If you answered "Yes" to Question 6i on page 4, multiply this amount by 1.10 to determine your monthly premium rate. For example, if your monthly premium rate shown in the Outline of Coverage is $100, multiply $100 by 1.10, which equals $110. This is your new monthly premium rate and this is the amount you need to show on line 7c.

8 PREMIUM PAYMENT OPTIONS - Total Amount you are Submitting for the Premium Period Selected in 7b.

IMPORTANT NOTE: Your monthly premium rate will differ depending on the Plan you choose and how you choose to pay. If you choose to pay using Electronic Funds Transfer (EFT), the monthly premium rate will be the same as shown in your Outline of Coverage. If you choose to have us bill you each month (Direct Billing), your monthly premium rate will be $2 more than the monthly premium rate shown in your Outline of Coverage. (You will see where to choose your payment option and how to calculate the amount below.)

☐ **MONTHLY PREMIUM RATE* -** Amount from 7cabove, plus the adjustment for choosing the Direct Billing option, if applicable.

a) Monthly Premium Rate $ _____ (EFT)

b) Monthly Premium Rate $ _____ (Direct Billing amount - please add $2 to the rate shown above in 7c)

☐ **QUARTERLY PREMIUM RATE** - (monthly rate from line 7c multiplied by 3) $ _____

☐ **SEMI-ANNUAL PREMIUM RATE** - (monthly rate from line 7c multiplied by 6) $ _____

☐ **ANNUAL PREMIUM RATE** - (monthly rate from line 7c multiplied by 12) $ _____

***If you are paying with a personal check, you must include at least the first month's premium with your application.**

Please make checks payable to **Aetna Life Insurance Company.**

9 REQUESTED EFFECTIVE DATE: 1st of _____ (month)

10 PAYMENT OPTIONS – Please select the method of payment for your premium payments.

☐ Electronic Funds Transfer (EFT) - complete the EFT information below.

☐ Bill me (Direct Billing) - I understand that if I choose to be billed on a monthly basis, my premium rate will be $2 more per month than if I were to choose a quarterly, semi-annual, or annual billing or the EFT option.

continued

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10 PAYMENT OPTIONS (Continued)

Electronic Funds Transfer (EFT) Option

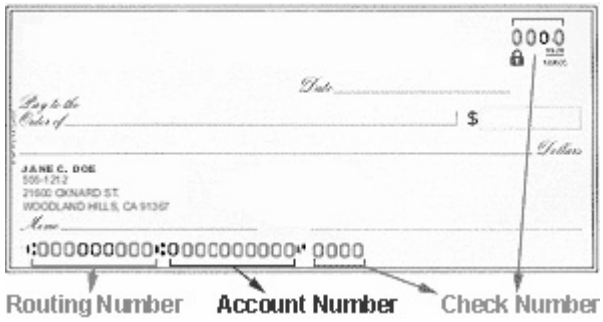
Checking Account Number: _____

Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Bank: _____

Name(s) on Checking Account: _____

Authorized Signature: _____



Terms of Agreement: My account at the institution named above 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 checking the Electronic Funds Transfer (EFT) Option box above and with my application signature on **Page 7, Section 11**, I am accepting the terms of the Electronic Funds Transfer Agreement. Aetna Individual Medicare Supplement Plan policyholders must continue to pay their Medicare Part B premium and Part A if applicable.

NOTE: Aetna reserves the right to refuse/terminate electronic payment services at any time. This agreement remains in effect until Aetna/member terminates it. Aetna may require 48 hours to process the policyholder's notice of termination.

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Applicant's Name	Social Security Number

11 RELEASE AUTHORIZATION – PLEASE READ CAREFULLY BEFORE SIGNING

Please sign and date where indicated on this page. **PLEASE MAKE A COPY FOR YOUR RECORDS**

IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN. By filing this Application and applying for this coverage, I 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 a timely and accurate payment of premiums and any other contribution provided in the plan documents. If premium payments are not paid on time and accurately, coverage will be terminated. If terminated for nonpayment of premium, I may no longer be eligible to enroll in Aetna's Individual Medicare Supplement Plan.
   Important Note: The Monthly Premium Rate(s) selected/calculated by the Applicant in Sections 7(c) and 8 will be validated for accuracy by Aetna prior to approval of this Application. If Aetna determines that an incorrect Monthly Premium Rate has been selected/calculated, the Applicant will be contacted by Aetna, the appropriate Monthly Premium Rate will be assessed and the Applicant will be required to acknowledge acceptance of the corrected Monthly Premium Rate prior to approval of this Application.
3. I authorize Aetna to request my medical records, any prescribed medication history and any other medical or pharmaceutical information to process my Application and to make a decision on the approval or disapproval of my Application. I authorize any physician, other healthcare professionals, hospital, clinics, labs, pharmacies, pharmacy benefit managers or any other healthcare organization ("Providers") that provided treatment or any other service to me 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 the closure of my 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 determination; 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 but no longer than thirty (30) months from the date this application is signed. 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 (or my authorized representative is) entitled to receive a copy of this Application upon request, and that a photocopy is as valid as the original.
6. Providers are independent contractors and are not agents of Aetna.
7. Information on insurance agent/broker compensation is available from your agent.
8. I have an obligation of communicating to Aetna in writing any medical conditions which occur to Applicant listed in this Application after the Application date and before the effective date of the coverage, if approved.

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

I acknowledge receipt of a copy of "A Guide to Health Insurance for People with Medicare" and an Outline of Coverage, and that I have made a copy of this Application.

Applicant's Signature: _____ Application Date: _____

Power of Attorney or Legal Guardian Signature*: _____

* If Applicant is unable to sign, a court-appointed legal guardian or a designee authorized by state law must sign above. Attach a copy of the document that designates this person as the Applicant's representative.

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Applicant's Name	Social Security Number

12 INSURANCE PRODUCER CERTIFICATION – This Section To Be Completed By Insurance Producer/Aetna Sales Representative Only

The undersigned Insurance Producer certifies that the Applicant has read, or had read to him/her, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

Did you see the proposed applicant at the time this application was executed? ☐ Yes ☐ No

If "No," please explain: _____

List all health insurance policies (including Medicare Supplement policies) you have sold to the applicant which are still in force. (attach separate sheet, if necessary)

Company: _____ Type: _____

Company: _____ Type: _____

List all health insurance policies sold to the applicant within the past 5 years which are no longer in force.

Company: _____ Type: _____

Company: _____ Type: _____

I certify: (1) I have accurately recorded the information supplied by the Applicant; and (2) I have given the Applicant an Outline of Coverage for the policy they are applying for and I reviewed the current health insurance coverage of the Applicant and find additional coverage of the type and amount applied for the Applicant's needs is:

☐ Appropriate ☐ Inappropriate

Signature of Insurance Producer *(Required, if applicable)*		**Signature of General Agent/FMO** *(Required, if applicable)*	
Date	E-mail Address	Date	E-mail Address
Name of Insurance Producer (print name)		Name of General Agent/FMO (print name)	
SS# of Insurance Producer		General Agent/FMO TIN Number	
TIN of Agency for Commissions if other than Insurance Producer		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 ( )

13 AETNA SALES REPRESENTATIVE

Last Name of Aetna Sales Representative (print name)	First Name of Aetna Sales Representative (print name)
Address of Aetna Sales Representative	Aetna Number
	Telephone Number of Aetna Sales Representative

Send Policy to: ☐ Producer ☐ Insured

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