Aetna Individual Medicare Supplement Plan Application
Aetna Life Insurance Company
[151 Farmington Avenue, MS 3128, Hartford, CT 06156]

[PLEASE MAIL APPLICATIONS TO:]
[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.** The sale of a Medicare supplement policy is prohibited where an individual has Medicare supplement coverage in force and does not desire to replace the existing policy or where the Medicare supplement policy would duplicate benefits to which the individual would be entitled under a Medicare Advantage plan. 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.)
- **Please answer all questions to the best of your knowledge and belief.**

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? ____________

(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 PLAN SELECTION AND PREMIUM PERIOD OPTIONS

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

[☐ Plan A ☐ Plan B ☐ Plan F]

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.)

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6 PREMIUM PAYMENT OPTIONS - Total Amount you are Submitting for the Premium Period Selected in **[**5b**]**.

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) **[**or with a Credit Card**]**, 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 **[**5c**]** above, plus the adjustment for choosing the Direct Billing option, if applicable.

a) Monthly Premium Rate $ ___________ (EFT **[**or Credit Card amount**]**)

b) Monthly Premium Rate $ ___________ (Direct Billing amount – please add $**[**2**]** to the rate shown above in **[**5c**]**)

☐ **QUARTERLY PREMIUM RATE** – (monthly rate from line **[**5c**]** multiplied by 3) $ ________________

☐ **SEMI-ANNUAL PREMIUM RATE** - (monthly rate from line **[**5c**]** multiplied by 6) $ ________________

☐ **ANNUAL PREMIUM RATE** (monthly rate from line **[**5c**]** 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]**.

7 REQUESTED EFFECTIVE DATE: 1st of ______________________ (month)

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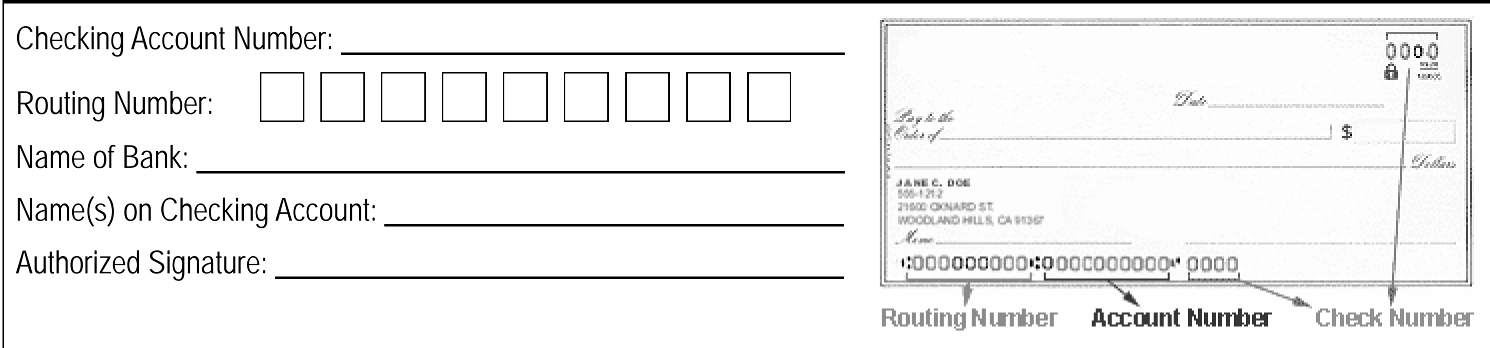
8	**PAYMENT OPTIONS –** Please select the method of payment for your premium payments.
	☐ Electronic Funds Transfer (EFT) - complete the EFT information below.
	[☐ Credit Card - complete the Credit Card Payment information below.]
	☐ Bill me (Direct Billing) - I understand that if I choose to be billed 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 [or Credit Card] option.

Electronic Funds Transfer (EFT) Option



Checking Account Number: ____________________

Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Bank: ____________________

Name(s) on Checking Account: ____________________

Authorized Signature: ____________________

[Credit Card Payment Option

Credit Card Type ☐ Visa™ ☐ MasterCard™	Cardholder's Name (exactly as it appears on the card)
Account Number ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐	Card Expiration Date]

Terms of Agreement: My account at the institution named above has sufficient funds [or an appropriate credit limit] 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) [or Credit Card Option] box above and with my application signature on **Page [6], Section [9]**, I am accepting the terms of the Electronic Funds Transfer [or Credit Card Option] 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

9 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 if you do not qualify because you are not enrolled in Medicare Parts A and B. 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 Section[s] [5(c) and 6] 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 I am entitled to receive a copy of this Application upon request, and that a photocopy is as valid as the original.
5. Providers are independent contractors and are not agents of Aetna.
6. Information on insurance agent/broker compensation is available from your agent.
7. 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 materially 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

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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10 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 ( )

11 [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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12 NOTICE OF COMPENSATION

[Producers (Brokers, Agents, Consultants): Licensed and appointed producers may earn compensation in the form of a commission on the sale of this product. The amount of compensation varies depending on a number of factors, including customer segment and the products selected. Aetna offers additional bonus programs to its producers, which may also apply. Please consult your broker for additional information concerning his/her compensation for this sale, including commission and any applicable bonus programs. The producer is prohibited by law from altering the amount of compensation received from Aetna based in whole or in part on the sale.]

[Salaried Aetna Employees: Salaried employees may earn compensation on the sale of Aetna products based on the services they provide, including providing quotes on, and explanations of, Aetna products. The compensation varies depending on a number of factors, including customer segment and products selected. Combining all factors, and excluding limited-benefit plans, compensation for each product quoted averages less than [0.80]% of the total first year annual premium. Aetna offers additional bonus programs, which may also apply. Neither Aetna nor the employee has material ownership interests in the other. The employee may not alter the amount of compensation received from Aetna. You may obtain additional information about the compensation expected to be received by eligible employees, based in whole or in part on the sale of an Aetna product, or alternative options presented, by contacting Aetna at https://www.aetna.com/about-aetna-insurance/contact-us/forms/employer/transparency.html.]

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