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: 800-260-9051 fax: 888-554-8312

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:

Nicole Pennington

530 Los Angeles Ave #115-189

Moorpark, CA 93021

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: 800-260-9051

Thank you for choosing...

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

Applicant's Social Security Number

Application ID Number

(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:

- Application must be completed by the Applicant in blue or black ink. **Please PRINT clearly. (A photocopy of this application will not be accepted.)**
- **This application must be completed in its entirety and one (1) form of payment selected or processing will be delayed.**
- Signature and date is required on **Page 7, Section K** for all applicants including spouse/domestic partner and children age 18 and over.
- PPO products are underwritten by **Aetna Life Insurance Company**.

Send completed Application to:
Aetna Advantage Plans
PO Box 14015
Lexington, KY 40512-4015

A. Applicant Information

Aetna Use Only Y – N – U	**Effective Date:**	**Number:**

Name

Maiden Name of Applicant/Spouse/Domestic Partner

Mailing Address (All Aetna correspondence will be sent to this address) – Include Apartment Number, if applicable.

Number, Street _____

County _____

City, State, ZIP Code _____

Telephone Numbers
Home ( )
Work ( )
Cell ( )

Billing Address (if you prefer your bill to be mailed to a different address than listed above.) – Include Apartment Number, if applicable.

Number, Street _____

City, State, ZIP Code _____

Marital Status
☐ Single ☐ Married
☐ Domestic Partner

Occupation

E-mail Address

Please check if applicable:
☐ I am eligible for health benefits offered by my employer
☐ I am a sole proprietor or I am self-employed

Do you read and write English?
☐ Yes ☐ No

Choose desired benefit plan type:
Managed Choice Open Access:
☐ 3500 ☐ 5000

Managed Choice Open Access Value:
☐ 2500 ☐ 8000
☐ High Deductible 3500 (HSA Compatible)
☐ High Deductible 5500 (HSA Compatible)
☐ Preventive and Hospital Care 3000 (HSA Compatible)
☐ MCOA 5000 with Limited RX
☐ MCOA 7500 with Unlimited Primary Care Visits plus Dental
☐ Dental (Dental option available only with choice of medical plan above.)

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.

Reason for Application:
☐ New Enrollment
☐ Add Spouse/Domestic Partner/Dependent Child to an Existing Plan
☐ Add Dependent Child To An Existing Plan
☐ Change Existing Benefit Plan
☐ Request for Rate Review

B. Individuals Covered ***(Dependent children are covered up to age 19; and between the ages of 19 through 22 with proof of full-time student status.)***

☐ ***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)	Full-time Student Age 19 or Older
APP	Applicant									**N/A**
SP	Spouse/Domestic Partner									**N/A**
01	Dependent									☐ Yes ☐ No
02	Dependent									☐ Yes ☐ No
03	Dependent									☐ Yes ☐ No

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

Applicant's Social Security Number

Application ID Number

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 names and relationship: _____ ID#: _____	
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 or had such insurance rescinded? ☐ Yes ☐ No If "Yes," provide the following information: Name: _____ 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: _____	Name: _____

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

Answer all questions & provide complete details to all "Yes" answers on Page 5, Section F.		**Missing information may delay processing this application.**
In the past five (5) years, has any person listed on this application 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, infections, corneal transplant; *Ears/Hearing:* loss of hearing, deafness, infections, eustachian tube dysfunction; *Nose/breathing:* deviated septum, polyps, adenoiditis, sinusitis; *Throat/Swallowing:* tonsillitis, strep throat, excessive snoring or sleep apnea?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D2.	**Skin Conditions/Disorders:** Acne, birthmarks, dermatitis, eczema, fungal infections, psoriasis, keratosis, warts, moles, pre-cancerous lesions, skin cancer, or melanoma, 2nd or 3rd degree burns, herpes, scars/keloid, or revisions of cosmetic or reconstructive surgery, excessive sweating?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D3.	**Musculoskeletal Conditions/Disorders:** Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as strain/sprain, fracture, arthritis, fibromyalgia, gout, herniated disc, joint replacement, internal/external fixations, permanent hardware, amputation/prosthesis?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D4.	**Respiratory Conditions/Disorders:** Allergies, sinusitis, bronchitis, asthma, pneumonia, shortness of breath, chronic cough, collapsed lung, emphysema, COPD, tuberculosis, fungal infections, difficulty breathing, spitting/coughing up blood?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D5.	**Digestive Conditions/Disorders:** Infections of mouth/throat/tonsils, problems with jaw or chewing, ulcers, hernia, gastric reflux, colitis, Crohn's Disease, Irritable Bowel Syndrome (IBS), chronic diarrhea, intestinal problems, colon polyps, rectal bleeding or hemorrhoids, diseases of the pancreas, liver or gallbladder, hepatitis A/B/C/other, jaundice, Cirrhosis, unexplained weight loss or gain, eating disorder, Gastric Bypass/Banding?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D6.	**Urinary Conditions/Disorders:** Bladder infections, kidney infections, stones, blood in urine, stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D7.	**Heart and Circulatory Conditions/Disorders:** Anemia, bleeding/clotting disorders, Hemophilia, thrombocytopenia, varicose/spider veins, Raynauds, phlebitis, thrombosis, enlarged lymph nodes or lymphadenitis, chest pain, angina, high/low blood pressure, hypertension, high cholesterol/lipids, heart murmur, palpitations, congestive heart failure, coronary artery disease, aneurysm, heart attack, bypass surgery/angioplasty, valve replacement, pacemaker or defibrillator, rheumatic fever?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D8.	**Metabolic and Endocrine Conditions/Disorders:** Diabetes, adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis, thyroid disorders, or other immune disorders (do not include the results of an HIV test)?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

Continued

Applicant's Social Security Number

Application ID Number

D. Health History for Applicant and ALL Dependents *(Continued)*

D9.	**Brain/Nervous System Conditions/Disorders:** Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, confusion, memory loss, Alzheimer's, dementia, head injury, stroke**,** migraine headaches or chronic severe headaches**,** narcolepsy, sleep apnea, tremors, Multiple Sclerosis, seizures/epilepsy, Muscular Dystrophy, Reflex Sympathetic Dystrophy (RSD)?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D10.	**Male Reproductive Conditions/Disorders:** Fertility/infertility, low sperm count, sexual dysfunction, erectile dysfunction, enlarged prostate, prostatitis, undescended testes, genital or anal herpes/warts or sexually transmitted diseases?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D11.	**Female Reproductive Conditions/Disorders:** a) Pelvic pain, abnormal menstrual bleeding, absence of menstruation, abnormal PAP smear, endometriosis, ovarian cysts, uterine fibroids, fertility/infertility, miscarriage, breast cysts/lumps/fibroids, breast implants, genital warts/herpes or sexually transmitted diseases?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
	b) Has it been more than 40 days since any female listed above had her last menstrual period? If "Yes," provide name(s) and reason(s). Name(s): _____ Reason(s): _____ _____ _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
	c) Has any ***female*** had an abnormal PAP Smear? If "Yes," provide details in **F1**. Date of last normal PAP Smear: Name: _____ Date: _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
	d) Is any ***female*** applying pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate? If "Yes," provide applicant name below. Name: _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D12.	**Nervous, Mental and Behavioral:** Depression, anxiety, attention deficit, chemical imbalance; bi-polar, obsessive-compulsive or panic disorders; substance abuse, eating disorders; counseling or support group, alcohol or chemical dependence, anorexia/bulimia, schizophrenia?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D13.	**Cancer/Tumors:** Cysts, tumors or abnormal growths, Hodgkin's disease, leukemia or any other cancer or malignancy?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D14.	**Birth Defects/Congenital Abnormalities:** Birthmarks, cleft palate/lip, club foot, webbed fingers/toes**;** developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation**;** skull /facial or other physical deformities; Cerebral Palsy?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
D15.	**Other Conditions:** Has any person applying consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s) not listed on this application?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

NOTE: Coverage will be effective if the answers to the questions in this application remain as stated on the effective date, to the best of the Applicant's knowledge or belief.

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

Answer all questions & provide complete details to all "Yes" answers on Page 5, Section F.	**Missing information may delay processing this application.**

In the past five (5) years, has any person listed on this application consulted a health care provider, received treatment (including prescription medications), or been hospitalized for any of the following conditions or diseases?

E1.	Is any ***male*** person applying for coverage expecting a child or in the process of adoption or surrogacy with anyone whether or not that person is applying for coverage on this application? If "Yes," provide name below. Name: _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E2.	Has any person been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? If "Yes," provide name(s) below. Name(s): Date Discontinued(s): _____ _____ _____ _____	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

Continued

Applicant's Social Security Number

Application ID Number

E. Health Related Questions *(Continued)*

E3.	Has any person applying for coverage ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal, or controlled IV drugs? If "Yes," provide name(s) below. Name(s): Type of Drug/Substance(s): Date Discontinued(s):	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E4.	Has any person applying for coverage consumed any alcoholic beverage in the last 6 months? (Amount: A drink is 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor.) Name(s): Type(s): Amount(s): per ☐ Day ☐ Week ☐ Month per ☐ Day ☐ Week ☐ Month	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E5.	Has any person applying for coverage been convicted of a DUI (drunk driving violation)? If "Yes," provide name(s), state(s) and dates. Name(s): State(s): Date(s):	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E6.	Has any person applying for coverage 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 ☐ App ☐ SP/DP ☐ Dep
E7.	Has any person applying for coverage had any ***abnormal*** lab results, X-rays, MRI or other diagnostic test results or physical exam results (do not include the results of an HIV test)?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E8.	Has any person applying for coverage been medically advised to undergo further medical testing, treatment or surgery which has not yet been completed?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E9.	Has any person applying for coverage been a patient in an outpatient clinic, hospital, surgical center, treatment center or other medical facility?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E10.	Has any person applying for coverage seen any health care provider for any condition, signs, or symptoms which have not yet been diagnosed?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E11.	Has any person applying for coverage smoked or used any tobacco products, such as snuff and/or chewing tobacco, in the last 2 years? If "Yes," provide name(s) below and dates. Name(s): Date(s) Stopped:	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E12.	Has any person applying for coverage taken prescription medications or been advised to take prescription medications in the last 2 years?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E13.	Has any person applying for coverage ever seen, received treatment from, or consulted any health care provider for any other condition or symptom(s) not listed on this application?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E14.	Is any person applying for coverage a candidate for, or a recipient of an organ, bone marrow, or stem cell transplant?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep
E15.	Is any person applying for coverage currently on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	☐ Yes ☐ No ☐ App ☐ SP/DP ☐ Dep

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

Applicant's Social Security Number

Application ID Number

F. Detailed Health Information

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

1. Provide COMPLETE DETAILS to ALL questions answered "Yes" in Sections D and E.

Family Code	Ques. No.	Dates From	Dates To	Explain Nature of Illness/Condition	Describe Treatment Received/Recommended	Do you consider yourself "Fully Recovered"?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

2. List all prescription medications and/or doctors' samples taken by you and/or your named dependents within the last 2 years.

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

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

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

Continued

Applicant's Social Security Number

Application ID Number

F. Detailed Health Information *(Continued)*

4. List last doctor visit for all family members, including routine check-ups.

Family Code	No Visit	Purpose of Visit	Date of Visit	Results of Visit	Name, Address and Phone Number of Physician
APP					
SP/DP					
01					
02					
03					

G. Effective Date (Requesting an effective date DOES NOT GUARANTEE underwriting to be completed before the date requested.

If Aetna approves my application, I am requesting an effective date of the ☐ 1st or the ☐ 15th of _____ (month).
You will be given the requested effective date if Aetna approves the application within 30 days. This date must be no later than 90 days after the signature date (**Page 7, Section K**) of this application. This date will be honored provided that Aetna's approval is within 30 days of the requested effective date. No requested effective date will be honored prior to or on the signature date.

H. Statement of Enrollment Conditions

Each member of the family will be medically underwritten separately and assigned a separate medical coverage based on 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.

I. Race/Ethnicity - Optional

Family Code	(This information is designed for the purpose of data collection and will not be used for determining eligibility, rating, or claim payment.)		
APP	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian– 04 ☐ Other – 05 _____	**01**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian– 04 ☐ Other – 05 _____
SP/DP	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian– 04 ☐ Other – 05 _____	**02**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian– 04 ☐ Other – 05 _____
		03	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian– 04 ☐ Other – 05 _____

Applicant's Social Security Number

Application ID Number

J. 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 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 cost sharing as outlined in the policy. If payment of premiums are not paid on time and accurately, your coverage will be terminated. If you are terminated for non payment of premium, you may no longer be eligible to enroll in any of Aetna's Plans. I agree to make co-payments and any other cost sharing as provided for in my policy, directly to providers of health care.
3. I authorize Aetna to request my and/or my dependents' (those who are applying for coverage under this application) 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 and/or my dependents' application for no more than 30 months from the date(s) of my/our signature(s) shown in **Section K** below. 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 me or any of my dependents applying for coverage under this application to disclose the information required by Aetna and described above to Aetna and/or its designated agents.

   The existence of such information and documentation as described above shall be disclosed under this Application. 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 further authorize Aetna to use such information and to disclose such information to affiliates, Providers, payors, 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.

   I have discussed the terms of this authorization with my spouse/domestic partner and competent adult dependents, and I have obtained their consent to those terms. I understand that this authorization is provided under state law and regulations. This authorization will remain valid for the term of the coverage and if so long thereafter as allowed by law. This authorization may be revoked by me at any time by completing the form entitled "Revocation of Authorization Previously Given to Aetna" available by calling the member service number on my ID card. I understand that Aetna will comply with the HIPAA Privacy Rules and that disclosure of information will be done under the rules of such Federal law.

   I understand and agree that Aetna will use any information supplied in this Application prior to the effective date of coverage in considering my application, including any medical information.

   I understand that I am entitled to receive a copy of this authorization upon request, and that a photocopy is as valid as the original.
4. I have an obligation of communicating to Aetna in writing any medical conditions which occur to myself or to any of my dependents listed in this Application after the signature of this Application and before the effective date of the coverage if approved.
5. I understand and agree that, with the exception of Aetna Rx Home Delivery, all participating providers and vendors are independent contractors and are neither insurance producers nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
6. Information on agent's compensation is available from your agent or at Aetna.com.
7. 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 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.

K. Signature(s) Required - All persons age 18 and over must sign and date below.
If person applying is a minor, the application must be signed by a parent or legal guardian

By signing below, I acknowledge that I have personally read, understand and agree to the terms and conditions on all the pages of this form and accept the use of binding arbitration.

I represent that all information supplied on this form is true and complete to the best of my knowledge. I have myself read, understand, and agree to the conditions of enrollment on this Application. I understand that the information supplied in this form will be decisive for the approval of my application and that any misrepresentation and/or mistake in such information will be reason for cancellation/termination of the coverage for which I am applying.

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

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. You will be able to confirm the identity of the person calling. Please do not answer any questions if you are not satisfied with the identity of the caller. The person calling will give you a number to confirm their identity. Please call if you have any doubts or problems with respect to the call or the process during the call.

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

Applicant's Social Security Number

Application ID Number

L. Important Applicant Information - Please Read Carefully

1. Coverage may be declined, or a premium adjustment made, based on information provided to Aetna during the application process. In the case of declination, you will receive a letter notifying you that your application has not been accepted. Specific details will be kept confidential. If all members on the application are denied coverage, the original check will be returned directly to the applicant.
2. Do ***not*** cancel other coverage presently in force until written notification is received from Aetna indicating that your application 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.

M. Initial Payment

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

N. Recurring or subsequent Payment

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

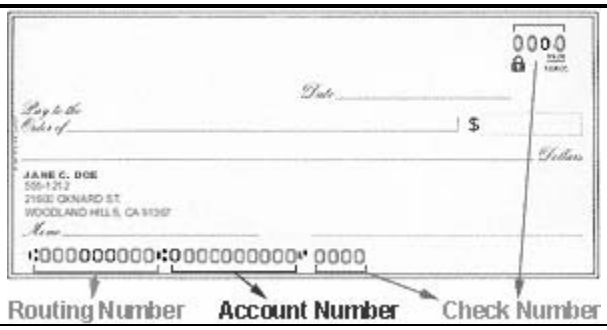
Easy Pay (Electronic Fund Transfer - EFT)

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 7, Section K**, I am accepting the terms of the Easy Pay Agreement.

Any rate adjustment made in accordance with the underwriting process will be automatically charged to your account upon approval of your application. Please be advised that such rate adjustment may result in an increase of 0% to 100% of the standard premium.

NOTE: Aetna reserves the right to refuse/terminate electronic payment services at any time. This agreement remains in effect until Aetna/member terminates it. Joint accounts require the signature of ALL account authorized persons (**Page 7, Section K**) even if not applying.

Credit Card Payment Option

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

Credit card payment is for your initial premium payment only and will be charged upon approval of your application. You must elect EFT or monthly billing for your next premium payment.

Any rate adjustment made in accordance with the underwriting process will be automatically charged to your account. Please be advised that such rate adjustment may result in an increase of **0% to 100% of the standard premium.**

O. Statement of Accountability - To be completed if the applicant cannot or has not completed the application.

I, _____, personally read and completed the Individual Application 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: _____

Applicant's Social Security Number

Application ID Number

P. 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:	☐ Yes ☐ No	☐ Yes ☐ No
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.		
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 Nicole@nicoleknowshealthinsurance.c	Date	E-mail Address
Name of Insurance Producer or Agency to be assigned as Broker of Record (print name) Nicole Pennington		Name of General Agent (print name)	
TIN Insurance Producer or Agency to be assigned as Broker of Record 455677948		Agent TIN Number	
Street Address (Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code) 530 Los Angeles Ave #115-189 Moorpark, CA 93021		Street Address (Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)	
Telephone Number 800-260-9051	Fax Number (888-554-8312	Telephone Number ( )	Fax Number ( )

Q. Aetna Sales Representative

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

R. Instructions

Please review these instructions.

- The applicant must complete the application. **You are responsible to ensure that the information on the application is correct, complete, and truthful.**
- Print clearly using blue or black ink. No pencil or correction fluid, please**.**
- This application must be received by Aetna's Medical Underwriting team within thirty (30) days from the signature date.
- Any misrepresentation of information on the application may result in cancellation of coverage.
- Your insurance will become effective only if this application is approved as applied 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 by Aetna. Do not cancel your current insurance coverage until you have been notified of approval by Aetna and your Aetna coverage is effective.

S. 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 phone number
- Incomplete mailing address information including city, state, and ZIP code.
- Incomplete answers to all application 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.**

T. Payment Options

Carefully read the instructions accompanying each payment option (Page 8, Sections M and N).

Applicant's Social Security Number

Application ID Number

U. Contact Information

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

Aetna Advantage Plans
PO Box 14015
Lexington, KY, 40512-4015

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

V. 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

W. 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 թարգման 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 مجاني 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 ਕੇਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

េសវាកម្មភាសាឥតគិតថ្លៃ ។ 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