

Medicare Supplement Application

Aetna Life Insurance Company

Aetna Administrator, P.O. Box 10374, Des Moines, IA 50306

INSTRUCTIONS:

To be considered complete, all sections on this form must be filled out, unless marked optional. Please sign the form. **Incomplete forms could delay processing your enrollment.** For information call **1-800-557-5078**; TDD (Hearing Impaired) **1-800-855-2881**. **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 whether you need multiple coverages.
- You may be eligible for benefits under Medi-Cal and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this extension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your suspended Medicare Supplement policy or, if that is no longer available, a substantially equivalent policy will be reinstated if requested within 90 days of losing Medi-Cal 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 reinstated 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 reinstated 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 reinstated 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 this state to provide advice concerning your purchase of Medicare Supplement insurance and medical assistance through the state Medi-Cal program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

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AETNA USE ONLY	
Effective Date	Rep Code(s)
ID Number	

1 Personal Information (Please Print)			
Last Name	First Name	MI	
Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date (MM/DD/YYYY)	
Street Address (Number, Street, Apt.)			
City	State	ZIP Code	County
Billing Address (if different from above)			
Telephone Number ()	Email Address (optional)		
Primary Language Spoken (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 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,

<p>(i) Did you turn age 65 in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(ii) Did you enroll in Medicare Part B in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF YES, what is the effective date? _____</p> <p>(iii) Are you covered for medical assistance through the state Medi-Cal program? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(A) NOTE TO APPLICANT: If you have a "Share of Cost" under the Medi-Cal program, please answer NO to this question. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(B) IF YES,</p> <p>(1) Will Medi-Cal pay your premiums for this Medicare Supplement policy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(2) Do you receive any benefits from Medi-Cal OTHER THAN payments towards your Medicare Part B premium? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(iv) 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 ____ / ____ / ____</p>	<p>(v) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(vi) Was this your first time in this type of Medicare plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(vii) Did you drop a Medicare Supplement policy to enroll in the Medicare Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(viii) Do you have another Medicare Supplement policy in force? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(A) IF YES, with what company and what plan do you have (optional for Direct Mailers)? _____</p> <p>(B) IF YES, do you intend to replace your current Medicare Supplement policy with this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(ix) Have you had coverage under any other health insurance plan within the past 63 days? (for example, an employer, union or individual plan) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(A) IF YES, with what company and what kind of policy? _____</p> <p>(B) IF YES, what are your dates of coverage under the policy? (if you are still covered under the other policy, leave "END" blank). START ____ / ____ / ____ END ____ / ____ / ____</p>
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4 Plan Selection (Note: Please make checks payable to Aetna Life Insurance Company)		
Premium Period: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	Insurance Plan Applied For: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan F	Initial Premium _____ (This amount, which can be found in the enclosed materials, must accompany the application.)

Name	Social Security Number
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5 Race/Ethnicity – Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)

White – 01
 African-American or Black - 02
 Hispanic or Latino - 03
 Asian - 04
 Other – 04 _____

6 Guaranteed Issue or Open Enrollment

Please note the following:

- 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.

7 Statement of Health Questions (Please answer the following questions regarding your health.)

If you are applying during open enrollment or you are eligible for guaranteed issue, you are not required to answer the following health questions.

1.	List current height _____ weight _____	
2.	Are you currently hospitalized, residing in a nursing home, enrolled in a hospice program, or expecting to enter a hospital or a nursing home within the next six (6) months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you been hospitalized within the past twelve (12) months for any condition including a nervous or mental disorder or drug and alcohol abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Do you currently require an oxygen tank or CPAP machine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	In the past two (2) years have you been medically treated or medically advised or had any recommended medical treatment or medical advise for:	
	a. Musculoskeletal conditions: Arthritis, osteoporosis, or bone, joint disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Respiratory conditions: Asthma, emphysema, Chronic Obstructive Pulmonary Disease (COPD) or chronic bronchitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Circulatory: Heart condition, stroke, high blood pressure, chest pains, anemia, heart attack, heart surgery, or blood vessel disease or surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. Urinary conditions: End stage renal disease, kidney dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	e. Endocrine and Metabolic conditions: Diabetes, unexplained weight loss, systemic lupus, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	f. Neurological conditions: Alzheimer’s disease, Parkinson’s disease or dementia, Multiple Sclerosis, Muscular Dystrophy, Amyotrophic Lateral Sclerosis (Lou Gehrig’s disease/ALS), Myasthenia Gravis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	g. Cancer: Leukemia, Hodgkin’s disease or any other type of cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	h. Digestive conditions: Ulcer, disorders of the stomach or liver, pancreatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	i. Other conditions: Have you had any other symptom, illness, injury, operation, impairment or any use of a prosthetic device, which has not already been mentioned above? IF YES, please list: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. If you answered **YES** to any of the above questions, please complete the following (add a separate page if necessary):

Question Number	Condition	Current Treatment	Date Treatment Started and Ended	Health Care Provider Name/Address/Telephone

7. Have you smoked or used any tobacco product within the past two (2) years? Yes No

8. Are you currently taking any prescription medications? Yes No
IF YES, please list medication (add a separate page if necessary):

Name of Medication	Name of Medication

Name	Social Security Number
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8 Release Authorization – PLEASE READ CAREFULLY BEFORE SIGNING. Please sign and date where indicated on this page. Keep the copy marked “Applicant” for your records.

No agent or other person except an executive officer of Aetna Life Insurance Company (Aetna) has power to make or modify any contract on behalf of Aetna or to waive any of Aetna’s rights or requirements. No waiver shall be valid unless in writing and signed by an executive officer of Aetna. No agent or other person except an executive officer of Aetna has the authority to waive the answer to any question herein, to modify this application, or to bind Aetna by making any promise or representation or by giving or receiving any information.

Disclosure of Information to Others - All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to law. In addition, information may be furnished to regulators of our business and to others, as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Authorization - All physicians and other health care professionals, hospitals and other health care institutions, insurers, medical or hospital service or pre-paid health plans, and employers are authorized to provide to Aetna information concerning health advice, treatment or supplies (including those related to mental illness) provided to me. This information will be used for the purpose of determining eligibility for coverage, where permitted under applicable law. This authorization will be valid for thirty (30) months from the date this application is signed. A photographic copy of this Authorization is as valid as the original.

NOTICE: CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

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.

I have read this application and the above conditions, and I understand and agree to them. I hereby certify that all statements and information given on this entire application -- including the Health Questions section, if applicable -- is true and correct to the best of my knowledge and belief. I understand that providing incomplete or false information on this application may allow Aetna to deny future claims and/or rescind my Policy. This application is submitted subject to all the terms and conditions of the Policy under which this application is made. I hereby accept all terms and conditions of the Policy. I understand that I must be a resident of the State of **California** at initial enrollment, and enrolled in Medicare Parts A and B. I understand that the policy will take effect on the policy date but not before the first premium is paid. **I also understand and agree that submission of this application and/or acceptance of plan premium payment by Aetna does not guarantee coverage.**

I acknowledge receipt of a copy of the “Buyer’s Guide to Health Insurance for People with Medicare,” an Outline of Coverage and 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.

9 This Section To Be Completed By Agent Only

List any other health insurance policies (including Medicare Supplement policies) you have sold to the applicant including (i) policies sold that are still in force and (ii) policies sold in the past 5 years that are no longer in force.

I have 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

Agent’s Signature _____ Date Signed: _____

Agent’s Name (Please Print) _____ Agent’s TID Number: _____

Agent’s Address and Telephone Number _____