

Name _____	Social Security Number _____
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5 PLAN SELECTION (Note: Please make checks payable to Aetna Life Insurance Company .)		
Premium Period: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual	Insurance Plan Applied For: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan F	Initial Premium (submit one month only) _____ (This amount, which can be found in the enclosed materials, must accompany the application.) Requested effective date: _____

6 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.	

7 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.																	
1.	Are you currently hospitalized, bedridden, confined to a nursing facility, require the use of a wheelchair, receiving home health care in the past 90 days; or has any such care been medically advised by a licensed medical practitioner? <input type="checkbox"/> Yes <input type="checkbox"/> No																
2.	In the past two (2) years , have you been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? <input type="checkbox"/> Yes <input type="checkbox"/> No																
3.	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? <input type="checkbox"/> Yes <input type="checkbox"/> No																
4.	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? <input type="checkbox"/> Yes <input type="checkbox"/> No																
5.	In the past two (2) years , have you consulted a physician, licensed medical provider, been diagnosed, treated or advised to have treatment for:																
a.	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? <input type="checkbox"/> Yes <input type="checkbox"/> No																
b.	Heart or circulatory surgery of any type including Angioplasty, Bypass, Stent Placement or a Valve Replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No																
c.	Cancer (except skin cancer), Melanoma, Hodgkin's Disease, Leukemia or Multiple Myeloma? <input type="checkbox"/> Yes <input type="checkbox"/> No																
d.	Mental or Nervous Disorder requiring Psychiatric care, Alcohol or Drug Abuse (prescription or non-prescription), Cirrhosis of the Liver or Hepatitis C? <input type="checkbox"/> Yes <input type="checkbox"/> No																
e.	Disabling/Crippling Arthritis, Osteoporosis with compression fractures, Degenerative Bone Disease, Systemic Lupus, or any other Connective Tissue Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No																
f.	Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other Lung Disease, or require the use of oxygen therapy to assist in breathing? <input type="checkbox"/> Yes <input type="checkbox"/> No																
6.	Have you been hospitalized two or more times within the past 24 months (2 years)? <input type="checkbox"/> Yes <input type="checkbox"/> No																
7.	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? <input type="checkbox"/> Yes <input type="checkbox"/> No																
8.	Have you taken any prescription medications within the past 12 months (1 year)? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES , provide details below (attach a separate sheet if necessary):																
	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:35%;">Medication</th> <th style="width:15%;">Dosage</th> <th style="width:35%;">Medication</th> <th style="width:15%;">Dosage</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Medication	Dosage	Medication	Dosage												
Medication	Dosage	Medication	Dosage														
9.	Have you smoked or used any tobacco product within the past two (2) years? <input type="checkbox"/> Yes <input type="checkbox"/> No																
10.	List current height _____ weight _____																

Fax completed application to: John Conner (800) 995-9913

PLEASE MAKE A COPY FOR YOUR RECORDS

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. 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, your coverage will be terminated. If you are terminated for nonpayment of premium, you may no longer be eligible to enroll in Aetna’s Individual Medicare Supplement Plan.
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 and so long thereafter as allowed by law. 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 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 or at Aetna.com.
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.
9. **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.
NOTICE: CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

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.

9 PRODUCER CERTIFICATION – This Section To Be Completed By Producer/Aetna Sales Representative Only

The undersigned Agent 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.

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: _____

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

Company: _____ Type: _____

I certify: (1) I have accurately recorded the information supplied by the Applicant; and (2) I have given an Outline of Coverage for the policy applied 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 Producer: _____ Date signed: _____

Name of Insurance Producer or Agency to be assigned as Broker of Record: **John Conner**

TIN of Producer or Agency to be assigned as Broker of Record: **547390801** SS# if Payee is an Individual: _____

Signature of General Agent or FMO (required if applicable) **N/A** Date signed: _____

Name of General Agent or FMO (required if applicable): _____

TIN of General Agent or FMO: **N/A** SS# if Payee is an Individual: _____

Address and Telephone Number: **10425 Saddle Creek Drive Sacramento CA. 95829 916-682-1117**

PLEASE NOTE: When commission is to be paid only to a Producer, include only Producer-specific information. When commission is to be paid to a Broker, Agency, GA or FMO, the TIN and signature are required.

Send Policy to: Agent Insured

PLEASE MAKE A COPY FOR YOUR RECORDS