



HIPAA* Coverage Form – CA

*(Health Insurance Portability and Accountability Act)

Please mail this form to:

Aetna
Attn: Unit 212
P.O. Box 730
Blue Bell, PA 19422

Demographic Information

Last Name, First Name, M.I.			
Home Address (P.O. Box not acceptable)			
City		State	Zip
Billing Address (If different than above address)			
City		State	Zip
		County (Required)	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security Number	Home Telephone Number

Dependent Information

1. Last Name, First Name, M.I.			
Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security Number
2. Last Name, First Name, M.I.			
Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security Number
3. Last Name, First Name, M.I.			
Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security Number

HIPAA Eligibility

1. Have you had a minimum of 18 months of continuous health coverage most recently under an Employers-sponsored group health plan that ended within the last 63 days for a reason other than fraud or non-payment of premium? Yes No
 If **Yes**, please attach the Certificate of Coverage provided by your former employer or carrier OR letter from your employer giving us the start and end date of coverage.
 Name of insurance carriers: _____ Telephone Number (____) _____
 If **No**, you are **not** eligible for this guarantee issue plan.

2. Were you eligible for COBRA? Yes No
 If **Yes**, Date coverage started (Mo/Day/Year): _____
 Date coverage ended (Mo/Day/Year): _____
 If **No**, please explain: _____

3. Are you currently covered by or eligible for Medicaid, Medicare or any other employer-sponsored Health insurance benefits or do you have other health coverage? Yes No
 If **Yes**, you are **not** eligible for this coverage.

4. Were you cancelled for fraud or non-payment of premium? Yes No
 If **Yes**, you are **not** eligible for this coverage.

5. If you applied for the Aetna Advantage Plans for Individuals and Families, the following requirements must be met:

- You must have applied for the Aetna Advantage Plans for Individuals and Families within 63 days of the end date of your previous plan.
- You must have inquired about the HIPAA plan within 30 days of the declination for enrollment in the Aetna Advantage Plans for Individuals and Families OR within 63 days of the previous plan.

Effective Date

Aetna may assign an effective date of the 1st or the 15th of the month following the approval date. Effective date must be within 63 days of the prior coverage termination date. Aetna may allow a retroactive effective date of the 1st or 15th of the month following the prior coverage termination date.

Conditions and Agreement

It is important that you read and understand the following before you sign.

Agreement

I, the undersigned, agree to the following:

1. No coverage will come into effect until Aetna notifies me in writing.
2. Coverage and benefits once they come to effect are contingent on timely and accurate payment of premiums and any other contribution provided in the plan documents. If payment of premiums or any other contribution is not paid in time and accurately your coverage will be terminated immediately. If you are terminated for nonpayment 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 contributions, as provided for in my plan documents, directly to providers of health care.
3. I understand and agree that, with the exception of Aetna Rx Home Delivery, all participating providers and vendors are independent contractors and are neither agents 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.
4. 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 material 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 subjects such person to criminal and civil penalties.

Authorization

I authorize any physician, other healthcare professional, hospital, pharmacy, pharmacy benefit manager or any other healthcare organizations ("Providers") to give Aetna or its agents information concerning the medical history, prescription history, services or treatment provided to the applicant listed on this HIPAA coverage form, including those involving mental health, substance abuse and AIDS/ARC. I further authorize Aetna to use such information and disclose 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 understand that this authorization is provided under state law, and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act ("HIPAA"). This authorization will remain valid for the term of the coverage and if so long thereafter as allowed by law. 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 HIPAA coverage form prior to the effective date in considering my application. 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.

Signature Required

I represent that all information supplied in this form is true and correctly recorded by me. I have myself read, understand and agree to the Conditions and Agreement. I understand that any misrepresentation and/or mistake in such information supplied, will be reason for cancellation/termination of coverage.

I UNDERSTAND THAT IF MY SIGNATURE/DATE DO NOT APPEAR AND/OR ARE NOT CURRENT AND/OR MY ANSWERS ARE INCOMPLETE, COVERAGE MAY BE AFFECTED.

Signature	Date
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Agent Information (If applicable)

1. Are you aware of any information not disclosed on this coverage form relating to the health, habits or reputation of the person listed on the coverage form which might have a bearing on the risk? Yes No
If **Yes**, please attach an explanation.
2. Did you see the person at the time this HIPAA Coverage Form was executed? Yes No
If **No**, please explain: _____

Agent Signature (<i>Required</i>)	Date (MM/DD/YYYY)	E-mail Address
Agent Name of (Print Name)		Agent TIN Number
Agent Street Address (Suite Number/Personal Mail Box Number)		
City/State/Zip Code	Agent Telephone Number	Agent Fax Number