New York Individual Advantage Application

1425 Union Meeting Road
PO Box 730
Blue Bell, PA 19422
1-800-435-8742

Aetna Health Inc. Use Only

Group Number:	Effective Date:

The effective date of your coverage depends upon receipt of a properly completed application and payment at Aetna Health Inc. If we receive a properly completed application and payment between the 1st and the 15th of the month, your coverage is effective on the first of the next month. If we receive payment between the 16th and 31st of the month, your coverage becomes effective the first of the month following 30 days.

1. Plan Option – *Please read instructions on reverse side before completing this form. Print clearly.*

Please check one plan: ☐ HMO ☐ QPOS

2. Subscriber Information

Last Name, First Name, M.I.	Social Security Number
Home Address (Street Address, Apt. Number, City, State, ZIP Code)	Telephone Numbers Home ( ) Work ( )

4.

	No.	Add	Remove	Last Name, First Name, M.I.	Sex M	Sex F	Birthdate MM / DD / YYYY	Social Security No.
Subscriber	a.	☐	☐		☐	☐	/ /	
Spouse	b.	☐	☐		☐	☐	/ /	
Children	c.	☐	☐		☐	☐	/ /	
* Attach sheet to list additional children	d.	☐	☐		☐	☐	/ /	
* Attach proof if full-time college student	e.	☐	☐		☐	☐	/ /	
	f.	☐	☐		☐	☐	/ /	

5.

	Change	Primary Office No.
a.	☐	
b.	☐	
c.	☐	
d.	☐	
e.	☐	
f.	☐	

Physicians' offices must be in the HMO Service Area.

6. Dependent Information

Do any of the dependents listed in #4 live at another address? ☐ Yes ☐ No

If Yes, who and at what address?

Explain the circumstances:

If any dependent's last name is different from yours, explain the circumstances:

3. Type of Activity

☐ **Converting coverage from a prior Aetna group plan?**
☐ **Yes** ☐ **No**

☐ New Subscriber
Effective Date ______

☐ Add/Remove Dependent
Reason ______
Date of Event ______

☐ Add/Continued Dependent coverage to age 30

☐ Name Change From ______
Date of Event ______

☐ Change of Primary Care Provider

☐ Withdrawal from Coverage
Date of Event ______

☐ Dependent Coverage:
☐ Add dependent over the limiting age, but less than 30
☐ Remove dependent over the limiting age, but less than 30

Reason:

Please make a copy for your records.

7. Other Health Benefits Coverage – (Please Note: If you are eligible for other benefits coverage, you may not be eligible for this policy.)

Are you employed? ☐ Yes ☐ No	If Yes, please give name and address of your employer.
Are you eligible for other health benefits coverage? (i.e., coverage under your spouse's employer's health benefits coverage, Medicare). ☐ Yes ☐ No	If Yes, please give name and policy of other insurance carrier of type of coverage. Are other family members eligible for coverage? ☐ Yes ☐ No If Yes, specify.
Are you replacing existing coverage? ☐ Yes ☐ No	If Yes, give name and policy number of other insurance carrier, date of termination, and specify those covered by policy.

8. Preexisting Conditions – Make certain you understand the following:

For a period of 12 months following the enrollment date, this plan excludes any service obtained by or on behalf of a Member for conditions (whether physical or mental) of the Member, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within six months of the enrollment date or as to a pregnancy existing on the enrollment date. In the case of pregnancy, coverage shall not be excluded for a period in excess of 10 months. The Member will be credited for time previously covered under Creditable Coverage, if the previous coverage was continuous to a date not more than 63 days prior to the enrollment date. In the case of previous health maintenance organization coverage, any affiliation period prior to that previous coverage becoming effective shall also be credited. This exclusion shall not apply to any Member that converts to this coverage immediately from Aetna Health Inc. HMO group coverage. **The plan will not impose a pre-existing condition exclusion with respect to an "eligible individual", as defined in Section 2741(b) of the Public Health Service Act.**

NOTE: The pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

I acknowledge that I have read and understand the above

Subscriber Signature ______________________________

Full monthly payment must accompany this application. Make check payable to **Aetna Health Inc**. **Sections 8** and **9 must** have subscriber's signature for application to be processed.

Application is not proof of coverage.

9. Subscriber/Dependent Signature – *Subscriber E-mail Address:*

I represent that to the best of my knowledge and belief all information on this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the subscriber copy of this application. I acknowledge receipt and agree to the terms of the individual contract. I authorize any hospital, physician, or other health care provider to furnish Aetna Health Inc. or its assignee or designee with such medical information about the subscriber and of the listed dependents as Aetna Health Inc. or its assignee or designee may require. I acknowledge that I, my spouse (if applicable), and any dependents listed above are not eligible for any group, Medicare, Medicaid or other health benefits coverage.

Signature	Date
Subscriber Signature	Date
Dependent Signature	Date
Dependent Signature	Date
Dependent Signature	Date

IMPORTANT EXPLANATORY INFORMATION Regarding Coverage for Dependants to age 30

The **subscriber** must continue coverage in order for the dependent to be covered in addition to the additional applicable eligibility criteria. A subscriber may request to continue an adult child as a dependent on his or her coverage even after the child reaches the limiting age under the terms of the policy if the adult child:

- is not yet 30 years old;
- is unmarried;
- lives, works or resides in New York state or in the service area of the insurer's network-based policy or contract; and
- is not covered as a named subscriber, enrollee or covered person under any other health plan including Medicare.

Individual Application Instructions

Complete all Sections if you are:

1. Enrolling as a new subscriber — **Complete Sections 2, 3, 4, 5 and 9 if you are changing a provider.**
2. Changing dependent coverage — **Complete Sections 2, 3 and 9 if you are terminating your Aetna Health Inc. coverage.**

Section 1 Check option you are selecting.

Section 2 Complete **all** information.

Section 3 Check box(es) indicating reason(s) for submitting form (i.e., new enrollment, coverage change, name change, withdrawal).

Section 4 Print your full name along with the name(s) of your dependent(s), if any. Provide sex, date of birth, and Social Security Number for each individual listed. If a dependent is a full-time college student, you ***must*** attach a current course schedule, or letter from the school confirming full-time student status (12 or more credits). The add/remove blocks should be checked **only** if you wish to add or remove a dependent from the plan.

Section 5 From the appropriate directory, choose the location number for primary physician (required for **all** members). Check the change block only if you are changing providers.

Section 6 This section **must** be completed for all new enrollments or dependent coverage changes.

Section 7 This section **must** be completed for all new enrollments or dependent coverage changes.

Section 8 This section **must** be completed for new enrollments and dependent coverage changes. Application or dependent coverage change will not be processed without signature.).

Section 9 Subscriber **must** sign **Sections 8** and **9** and date this form for any activity or it will not be processed.

Conditions of Enrollment

Subscriber Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. Enrollment of myself and of the listed dependents into the plan shall be effective on acceptance by Aetna Health Inc.
2. I am applying for individual coverage for myself, my spouse and any eligible children under 26 years of age (the limiting age) and neither my spouse nor children are eligible for group health benefits coverage.
3. I am applying for coverage for an eligible adult child up to age 30 as described above and in the policy document.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the Individual Contract. Terminations will be processed back to members paid date.
5. As a condition to coverage for most in-network (referred) benefits, I understand and agree that (with the exception of emergency procedures as defined in the Individual Contract) all services, in order to be covered by Aetna Health Inc., must be performed either by a participating primary care physician or by the participating specialist, hospital, or other provider as authorized by prior written referral from a participating primary care physician.
6. I agree to make directly to providers of health care such copayments as are provided for in the Individual Contract.
7. The Individual Contract will determine the rights and responsibilities of member(s) and will govern in the event it conflicts with any benefits comparison, summary, or other description of the HMO Plan.
8. I understand that this coverage will remain in effect regardless of the continued availability of a particular primary care physician or other health care provider.
9. I acknowledge that Aetna Health Inc. participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of Aetna Health Inc.
10. In New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of a 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 civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.