



- CO

Essential Premier Health Insurance\*



Subscriber's Social Security Number

Enrollment Form ID Number

Instructions:

- Enrollment Form must be completed by the Subscriber in blue or black ink. (A photocopy of this Enrollment Form will not be accepted.)
This Enrollment Form must be completed in its entirety and one (1) form of payment selected or processing time will be delayed.
Signature and date is required on Page 4, Section J and Page 5, Section L for all Subscribers including spouse or domestic partner and children age 18 and over.
Underwritten by Aetna Life Insurance Company through an AARP group trust arrangement in the District of Columbia.
Any family member currently pregnant (whether or not listed on this Enrollment Form) or in the process of adoption or surrogacy does not qualify for this program.
Subscribers may qualify and enroll for this program after delivery or adoption placement.

For assistance with this enrollment form, please call 1-866-660-4081.

Send completed Enrollment Form to:

Aetna - AARP Plans
Mailstop U22N
P.O. Box 3013
Blue Bell, PA 19422

A. Subscriber Information

Form A: Subscriber Information. Includes fields for Name, Mailing Address, Telephone Numbers, Billing Address, Marital Status, Occupation, E-mail Address, and Deductible options. Includes checkboxes for 'Aetna Use Only Y-N-U', 'Effective Date', and 'Number'.

B. Individuals Covered (Dependent children are covered up to age 25.)

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 Enrollment Form.

Table with columns: 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). Rows include Applicant (APP), Spouse or Domestic Partner (SP), and Dependents (01, 02, 03).

C. Other Insurance - Please attach copy of Continuation of Coverage Certificate letter for each Subscriber, if applicable.

Form C: Other Insurance. Includes questions about current health care coverage, spouse/children coverage, previous insurance, and Medicare eligibility.

\*In some states, sole proprietors may be eligible for Small Group Healthcare plans.



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| Subscriber's Social Security Number |  |  |  |  |  |  |  |  |  |
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**D. Health History for Subscriber and ALL Spouse or Domestic Partner/Dependents (Include information for all persons enrolling for coverage.)**

Answer all questions & provide complete details to all "Yes" answers on Page 3, Section F. Missing information may delay processing this Enrollment Form.

|   |   |  |
|---|---|--|
| In the past five (5) years, has any person listed on this Enrollment Form consulted a health care provider, received treatment (including prescription medications) or been hospitalized for any of the following conditions or diseases? |   |  |
| D1.   | <b>Eyes, Ears, Nose and Throat Conditions/Disorders:</b> <i>Eyes/sight:</i> glaucoma, cataracts, crossed eyes, detached retina, corneal transplant, infections; <i>Ears/Hearing:</i> loss of hearing, deafness, infections, eustachian tube dysfunction; <i>Nose/breathing:</i> deviated septum, polyps, adenoiditis, sinusitis; <i>Throat/Swallowing:</i> tonsillitis, strep throat, excessive snoring or sleep apnea, etc.?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D2.   | <b>Skin Conditions/Disorders:</b> 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, etc.?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D3.   | <b>Musculoskeletal Conditions/Disorders:</b> 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, etc.?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D4.   | <b>Respiratory Conditions/Disorders:</b> Allergies, sinusitis, bronchitis, asthma, pneumonia, shortness of breath, chronic cough, collapsed lung, emphysema, COPD, tuberculosis, fungal infections, difficulty breathing, spitting/coughing up blood, etc.?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D5.   | <b>Digestive Conditions/Disorders:</b> 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 gall bladder, hepatitis A/B/C/other, jaundice, Cirrhosis, unexplained weight loss or gain, eating disorder, Gastric Bypass/Banding, etc.?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D6.   | <b>Urinary Conditions/Disorders:</b> Bladder infections, kidney infections, stones, blood in urine, stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting, etc.?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D7.   | <b>Heart and Circulatory Conditions/Disorders:</b> 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, etc.? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D8.   | <b>Metabolic and Endocrine Conditions/Disorders:</b> Diabetes, adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis, thyroid disorders, AIDS/ARC, or other immune disorder (not including the result for the HIV test)?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D9.   | <b>Brain/Nervous System Conditions/Disorders:</b> 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), etc.?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D10.  | <b>Male Reproductive Conditions/Disorders:</b> Fertility/infertility, low sperm count, sexual dysfunction, erectile dysfunction, enlarged prostate, prostatitis, undescended testes, genital or anal herpes/warts or sexually transmitted diseases, etc.?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D11.  | <b>Female Reproductive Conditions/Disorders:</b><br>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, etc.?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   | 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.<br>Subscriber Name(s): _____ Reason: _____<br>_____   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   | c) Has any <b>female</b> had an abnormal PAP Smear? If "Yes," provide details in F1.<br>Date of last normal PAP Smear: _____<br>Subscriber Name: _____ Date: _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   | d) Is any <b>female</b> Subscriber pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate? If "Yes," provide subscriber name below.<br>Subscriber Name: _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D12.  | <b>Nervous, Mental and Behavioral:</b> 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, etc.?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D13.  | <b>Cancer/Tumors:</b> Cysts, tumors or abnormal growths, Hodgkin's disease, leukemia or any other cancer or malignancy?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D14.  | <b>Birth Defects/Congenital Abnormalities:</b> 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, etc.?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D15.  | <b>Other Conditions:</b> Has any Subscriber consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s) not listed on this Enrollment Form?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**NOTE: Medical conditions that occur after the signature date and before the effective date of the coverage if approved will be considered in the final underwriting decision. You shall communicate any medical condition occurring during such period.**

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| Subscriber's Social Security Number |  |  |  |  |  |  |  |  |  |
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**E. Health Related Questions (Include information for all persons enrolling for coverage.)**

|   |   |   |
|---|---|---|
| <b>Answer all questions &amp; provide complete details to all "Yes" answers on Section F below.</b> |   | <b>Missing information may delay processing this Enrollment Form.</b> |
| E1.   | Is any <b>male</b> Subscriber expecting a child or in the process of adoption or surrogacy with anyone whether or not that person is enrolling for coverage on this Enrollment Form? If "Yes," provide Subscriber name below.<br>Subscriber Name: _____   | <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| E2.   | Has any Subscriber been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? If "Yes," provide Subscriber name(s) below.<br>Subscriber Name: _____ Subscriber Name: _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| E3.   | Has any Subscriber ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal, or controlled IV drugs?<br>Subscriber Name: _____ Type of Drug/Substance: _____ Date Discontinued: _____<br>Subscriber Name: _____ Type of Drug/Substance: _____ Date Discontinued: _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| E4.   | Has any Subscriber 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.)<br>Subscriber Name: _____ Type: _____ Amount: _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month<br>Subscriber Name: _____ Type: _____ Amount: _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month | <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| E5.   | Has any Subscriber been convicted of a DUI (drunk driving violation)? If "Yes," provide Subscriber name(s), state(s) and date(s).<br>Subscriber Name: _____ State: _____ Date: _____<br>Subscriber Name: _____ State: _____ Date: _____   | <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| E6.   | Has any Subscriber 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), or tested positive for HIV (Human Immunodeficiency Virus)?  | <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| E7.   | Has any Subscriber had any <b>abnormal</b> lab results, X-rays, MRI or other diagnostic test results or physical exam results?  | <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| E8.   | Has any Subscriber been medically advised to undergo further medical testing, treatment or surgery which has not yet been completed?  | <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| E9.   | Has any Subscriber been a patient in an outpatient clinic, hospital, surgical center, treatment center or other medical facility?   | <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| E10.  | Has any Subscriber seen any health care provider for any condition, signs, or symptoms which have not yet been diagnosed?   | <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| E11.  | Has any Subscriber smoked or used tobacco products, such as Snuff and/or chewing tobacco, in the last 2 years? If "Yes," provide Subscriber(s) below.<br>Subscriber Name: _____ Date Stopped: _____<br>Subscriber Name: _____ Date Stopped: _____   | <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| E12.  | Has any Subscriber taken prescription medications or been advised to take prescription medications in the last 2 years?   | <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| E13.  | Has any Subscriber ever seen, received treatment from, or consulted any health care provider for any other condition or symptom(s) not listed on this Enrollment Form?  | <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| E14.  | Is any Subscriber a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?   | <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| E15.  | Is any Subscriber currently on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?   | <input type="checkbox"/> Yes <input type="checkbox"/> No              |

**F. Detailed Health Information**

Check here if more space is needed. Use a separate sheet of paper and staple to the back of this Enrollment Form.

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

| Family Code* | Ques. No. | Dates |    | Explain Nature of Illness/Condition | Describe Treatment Received/Recommended and Any Limitations if Applicable | % of Recovery |
|--------------|-----------|-------|----|-------------------------------------|---|---------------|
|              |           | From  | To |                                     |   |               |
|              |           |       |    |                                     |   |               |
|              |           |       |    |                                     |   |               |

**2. List all prescription medications and or doctor's samples taken by you and/or your named spouse or domestic partner/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 spouse or domestic partner/dependents consulted. If None, please state "None."**

| Family Code* | Question Number and/or Reason | Name, Address, and Phone Number of Attending Physician |
|--------------|-------------------------------|--|
|              |                               |  |
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| Subscriber's Social Security Number |
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**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 |
|  |           |                  |               | Normal           | Abnormal: Give Details |  |
| APP  |           |                  |               |                  |                        |  |
| SP   |           |                  |               |                  |                        |  |
| 01   |           |                  |               |                  |                        |  |
| 02   |           |                  |               |                  |                        |  |
| 03   |           |                  |               |                  |                        |  |

\*See Page 1, Section B.

**G. 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.) |    | <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02<br><input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____ |
|-------------|---|----|---|
| APP         |   | 01 | <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02<br><input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____ |
| SP          |   | 02 | <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02<br><input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____ |
| 01          |   | 03 | <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02<br><input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____ |
| 02          |   |    |   |
| 03          |   |    |   |

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

If Aetna approves my Enrollment Form, I am requesting an effective date of the 1st of \_\_\_\_\_ (month).  
 You will be given the requested effective date if Aetna approves the Enrollment Form within 30 days. This date must be no later than 90 days after the signature date (Page 5, Section L) of this Enrollment Form. 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.

**I. 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 Subscriber, 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 Enrollment Form via email.

The information I obtained to assist in enrolling for this coverage was provided to me:  In person     Over the phone     On the web

**J. AARP Joinder Agreement**

I, \_\_\_\_\_, have chosen one of the AARP individually underwritten health group products. I understand that such products are underwritten by Aetna Life Insurance Company (the "Insurer") through the AARP Health Group Trust (the "Trust"). To receive coverage under the products I have chosen I understand that I will have to join and participate in the Trust and be a member in good standing of AARP or a spouse or domestic partner and/or dependent of an AARP member, as defined in the coverage documents. I also fully understand and agree that no coverage shall become or remain effective as to an subscriber (myself, my spouse or domestic partner or dependents) if subscriber (myself, spouse or domestic partner or dependents) fails to meet minimum underwriting or eligibility requirements of AARP and/or Aetna. Each subscriber who meets the requirements will be offered coverage. I agree to the enrollment criteria as I myself indicated in the Statement of Enrollment Conditions section of this form.

I, the undersigned, also: 1) agree to be bound by the terms of the policy (including all of its attached documentation) issued to the trustee of the Trust (including any amendments); 2) request coverage for myself and/or for my spouse or domestic partner and/or dependents under the policy or policies issued to the Trustee (subject to the applicable underwriting requirements of the Insurer) and that such coverage become effective as of the date of my or my spouse or domestic partner and/or dependents approval for participation under the Trust; 3) agree that the covered benefits provided shall be in accordance and shall be subject to the terms of the policy or policies issued to the Trust; 4) agree to make the required contributions and payment of premiums to the Trust; and 5) also agree that in the case of default, fraud or no payment I will be liable to AARP and the Insurer for such fraud, or unpaid contributions for the coverage period, and AARP and the Insurer may terminate coverage.

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

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**K. Conditions and Agreement - Please Read Before Signing Below.**

**IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN. By filing this Enrollment Form and enrolling for this coverage, I on behalf of myself and the spouse or domestic partner and/or dependents listed on this Enrollment Form, agree to or with the following:**

1. Aetna may decline this Enrollment Form. No coverage comes into effect until Aetna approves this Enrollment Form.
2. Coverage and benefits, once they come into 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 authorize Aetna to request my and/or my spouse or domestic partner and/or dependents' (those who are enrolling for coverage under this Enrollment Form) medical records, any prescribed medication history and any other medical or pharmaceutical information to process my Enrollment Form and to make a decision on the approval or disapproval of my and/or my spouse or domestic partner and/or dependents' Enrollment Form. 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 spouse or domestic partner and/or dependents enrolling for coverage under this Enrollment Form 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 Enrollment Form. I understand that Aetna will rely on such information to: 1) underwrite this Enrollment Form for coverage, make eligibility, risk rating, policy issuance and enrollment determinations for all of the Subscribers; 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 or 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. 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 Enrollment Form prior to the effective date of coverage in considering my Enrollment Form, 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 spouse or domestic partner and/or dependents listed in this Enrollment Form after the signature of this Enrollment Form 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 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.
6. Information on agent's compensation is available from your agent or at Aetna.com.
7. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

**Attention Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.**

**L. Signature(s) Required - All Subscribers age 18 and over must sign and date below.**

**If Subscriber is a minor, the Enrollment Form must be signed by a parent or legal guardian.**

**I represent that all information supplied on this form is true, complete, and correctly recorded by me. I have myself read, understand, and agree to the conditions of enrollment on this Enrollment Form. I understand that the information supplied in this form will be decisive for the approval of my enrollment and that any misrepresentation and/or mistake in such information will be reason for cancellation/termination of the coverage for which I am enrolling.**

**I UNDERSTAND THAT IF MY SIGNATURE/DATE DO NOT APPEAR AND/OR ARE NOT CURRENT AND/OR MY ANSWERS ARE INCOMPLETE, my enrollment will be declined.**

**Once you submit this Enrollment Form, you may be contacted at any time via telephone by an Aetna representative to complete your enrollment 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.**

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

|                                     |  |  |  |  |  |  |  |  |  |
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| Subscriber's Social Security Number |  |  |  |  |  |  |  |  |  |
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**M. Important Subscriber Information Please Read Carefully**

- Coverage may be declined, or a premium adjustment made, based on information provided to Aetna during the enrollment process. In the case of denial, you will receive a letter notifying you that your enrollment has not been accepted. Specific details will be kept confidential. If all persons on the Enrollment Form are denied coverage, the original check will be returned directly to the Subscriber.
- Do **not** cancel other coverage presently in force until written notification is received from Aetna indicating that your enrollment has been approved and you and covered spouse or domestic partner and/or dependents are in receipt of your member ID card(s) providing the effective date of coverage.

**PAYMENT OPTIONS**

**N. Easy Pay (Electronic Fund Transfer) (By selecting this option you are approving the automatic withdrawal of your initial premium and all subsequent premium payments.)**

**Yes**, I would like to use Easy Pay.

Checking Account Number: \_\_\_\_\_

Routing Number:

Name of Bank: \_\_\_\_\_

Name(s) on Checking Account: \_\_\_\_\_



Routing Number      Account Number      Check Number

**No**, I do not want to use Easy Pay. Please bill me each month.

**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 each month. No bill will be issued.** I understand that by checking the "Yes" box above and with my Enrollment Form signature on **Page 5, Section L**, 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. Please be advised that such rate adjustment may result in an increase of 25% to 50% of the standard premium.**

**NOTE: The initial premium payment will be deducted upon approval of your Enrollment Form.** 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 5, Section L**) even if not enrolling.

**O. Credit Card Payment Option**

|   |  |   |  |                      |   |
|---|--|---|--|----------------------|---|
| Credit Card Type<br><input type="checkbox"/> Visa <input type="checkbox"/> MasterCard   |  | Cardholder's Name (exactly as it appears on the card) |  |                      |   |
| Account Number<br><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |  |   |  | Card Expiration Date | Card Verification Code*<br><input type="text"/> <input type="text"/> <input type="text"/> |

**Credit card payment is for your initial premium payment only and will be charged upon approval of your Enrollment Form. You will receive a bill on your next billing statement.**

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 25% to 50% of the standard premium.

\*The Verification Code can be found on the back of your credit card. This 3-digit code is usually the last three digits located in the signature panel.

**P. Payment by Personal Check or Money Order**

Please include a personal check or money order made payable to "Aetna" and attach to your completed Enrollment Form.

**Q. Statement of Accountability - To be completed if the Subscriber cannot or has not completed the Enrollment Form.**

I, \_\_\_\_\_, personally read and completed the Individual Enrollment Form for the Subscriber named below because:     Subscriber does not read English     Subscriber does not speak English     Subscriber 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 Subscriber: \_\_\_\_\_

|                                     |  |  |  |  |  |  |  |  |  |
|-------------------------------------|--|--|--|--|--|--|--|--|--|
| Subscriber's Social Security Number |  |  |  |  |  |  |  |  |  |
|                                     |  |  |  |  |  |  |  |  |  |

|                           |  |  |  |  |  |  |  |  |  |
|---------------------------|--|--|--|--|--|--|--|--|--|
| Enrollment Form ID Number |  |  |  |  |  |  |  |  |  |
|                           |  |  |  |  |  |  |  |  |  |

**R. Insurance Producer Information (If applicable)**

|  |  |  |  |   |                   |
|--|--|--|--|---|-------------------|
| 1. Are you aware of any information not disclosed on this Enrollment Form relating to the health, habits, or reputation of any person listed on this Enrollment Form which might have a bearing on the risk?<br>If "Yes," please attach explanation. |  | <b>General Agent</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | <b>Insurance Broker</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No |                   |
| 2. Did you see the proposed subscriber at the time this enrollment form was executed?<br>If "No," please explain: <b>faxed application</b>   |  | <input type="checkbox"/> Yes <input type="checkbox"/> No                         |  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                 |                   |
| <b>Signature of Insurance Producer</b> (Required if applicable)   |  |  | <b>Signature of General Agent</b> (Required if applicable)                         |   |                   |
| Date   | E-mail Address<br><b>jay@insuranceshoppers.net</b> |  | Date   | E-mail Address  |                   |
| Name of Insurance Producer or Agency to be assigned as Broker of Record (print name)<br><b>Insurance Shoppers, Inc.</b>  |  |  | Name of General Agent (print name)   |   |                   |
| TIN of Producer or Agency to be assigned as Broker of Record<br><b>TIN: 20-4940295</b>   |  |  | Agent TIN Number   |   |                   |
| Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)<br><b>450 Hickory Street, Broomfield, CO 80020</b>  |  |  | Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code) |   |                   |
| Telephone Number<br><b>(720) 352-7561</b>  |  | Fax Number<br><b>(866) 698-4597</b>  | Telephone Number<br>( )  |   | Fax Number<br>( ) |

**S. Aetna-appointed Sales Representative**

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

**T. Instructions**

**Please review these instructions.**

- The Subscriber must complete the Enrollment Form. You are responsible to ensure that the information on the Enrollment Form is correct, complete, and truthful.
- Print clearly using blue or black ink. No pencil or correction fluid, please.
- This Enrollment Form must be received by Aetna's Medical Underwriting team within thirty (30) days from the signature date.
- Any misrepresentation of information on the Enrollment Form may result in cancellation of coverage.
- Your insurance will become effective only if this Enrollment Form is approved as enrolled for and the appropriate premium is enclosed.

*You are ineligible for coverage if Subscriber is currently pregnant (whether or not listed on the Enrollment Form) or in the process of adoption; or any non-citizen Subscriber has not resided in the U.S. for the last six (6) consecutive months.*

**Coverage is not guaranteed until approved in writing by Aetna. Do not cancel your current insurance coverage until you have been notified of approval by Aetna and your Aetna coverage is effective.**

**U. Effective Date**

Dates are assigned to the 1st 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 telephone number
- Incomplete mailing address information including city, state, and ZIP code.
- Incomplete answers to all Enrollment Form 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.**
- If the Subscriber chooses a PPO product, complete the Joinder agreement section.

**V. Payment Options**

**Carefully read the instructions accompanying each payment option (Page 6, Sections N, O and P).**

**W. Contact Information**

Please return this Enrollment Form to the agent or submit to the address listed below.

**Aetna – AARP Plans  
Mail Stop U22N  
P. O. Box 3013  
Blue Bell, PA 19422  
Fax #: 866-223-2041**



Essential Premier Health Insurance



# Determination of Self-Employed Business Group of One

**A. All Applicants must complete the questions below to determine if you meet the legal definition of a “self-employed business group of one” in Colorado.**

|   |  |
|---|--|
| 1. Are you either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Do you have gross income from your self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years?<br><b>Note:</b> Substantial part of your income means income derived from business activities of the business group of one that are sufficient to pay for the annual premiums for the business group of one’s health benefit plan.? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Do you work a minimum of 24 hours a week on a permanent basis?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Instructions**

- If you answered **No** to **ANY** of the questions above, please sign and date **Section D** below.
- If you answered **Yes** to **ALL** of the above questions, please complete **Sections B, C** and **D** below.

**B. If you waive coverage for a family member who will not be covered by this policy, you must list the other coverage for that dependent and when it becomes effective.**

| Family Member | Full Name | Other Coverage Name | Other Coverage Effective Date |
|---------------|-----------|---------------------|-------------------------------|
| Spouse        |           |                     |                               |
| Dependent     |           |                     |                               |
| Dependent     |           |                     |                               |
| Dependent     |           |                     |                               |

**C. Disclosure (Please read and sign the following disclosure required by Colorado law.)**

I \_\_\_\_\_, meet the definition of a self-employed business group of one as attested to on the (name of applicant)

above Determination of Self-Employed Business Group of One Form. I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three (3) year period. I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of plan design, my age, my health status and that of my dependents, overall cost and utilization trends, and tobacco use. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited to plan design, the carrier’s overall cost and utilization trends (“index rate”), my age, my family size, and a factor that reflects the cost of care where I live. I have been given a health plan description form showing the benefits under **Colorado’s** small group Standard Health Benefit Plans. I have also been given a **Colorado** Health Plan Description Form for the plan for which I am applying.

**D. Signature**

I hereby attest that the answers to the questions contained in this form are true and correct.

|                     |      |
|---------------------|------|
| Applicant Signature | Date |
|---------------------|------|

**Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.**



Essential Premier Health Insurance



# Additional Coverage Information – CO

|                                     |  |  |  |  |  |  |  |  |  |
|-------------------------------------|--|--|--|--|--|--|--|--|--|
| Subscriber's Social Security Number |  |  |  |  |  |  |  |  |  |
|                                     |  |  |  |  |  |  |  |  |  |

|                           |  |  |  |  |  |  |  |  |  |
|---------------------------|--|--|--|--|--|--|--|--|--|
| Enrollment Form ID Number |  |  |  |  |  |  |  |  |  |
|                           |  |  |  |  |  |  |  |  |  |

- You normally do not require more than one policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy.
- If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.

### A. To the best of your knowledge:

|   |  |
|---|--|
| 1. Do you have another insurance policy or contract in force?<br>a) If Yes, provide company name and policyholder number:<br>Company Name _____ Policyholder Number _____   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) If Yes, do you intend to replace your current accident and sickness insurance with this policy (contract)?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Do you have any other accident and sickness insurance that provides benefits similar to this accident and sickness policy?<br>a) If Yes, provide company name and policyholder number:<br>Company Name _____ Policyholder Number _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) If Yes, provide type of policy:<br>Type of Policy _____  |  |
| 3. Are you covered for medical assistance through the state Medicaid program?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| a) As a Specified Low Income Medicare Beneficiary (SLMB)?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) As a Qualified Medicare Beneficiary (QMB)?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c) For other Medicaid medical benefits?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |

### B. Producers shall list any other accident and sickness insurance they have sold to the Applicant.

|  |
|--|
| 1. List policies sold which are still in force.                                |
|  |
| 2. List policies sold in the past five (5) years which are no longer in force. |
|  |



Essential Premier Health Insurance



# Notice To Applicant Regarding Replacement of Accident and Sickness Insurance

Aetna – AARP Plans  
Mail Stop U22N  
P. O. Box 3013  
Blue Bell, PA 19422

According to the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Aetna Life Insurance Company. Your new policy will provide 10 days of free look period, days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

### Statement To Applicant By Issuer or Producer

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits
- No change in benefits, but lower premiums
- Fewer benefits and lower premiums
- Other (please specify): \_\_\_\_\_

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.
2. State law provides that your replacement policy or contract may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If, you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

**Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.**

|  |      |
|--|------|
| Producer or Other Representative Signature*  | Date |
| Print Name and Address of Issuer or Producer |      |
| Applicant Signature                          | Date |

\*Signature not required for direct response sales.