Aetna Group Questionnaire

☐ **Aetna Health Inc.**
1425 Union Meeting Road
Blue Bell, PA 19422

☐ **Aetna Health Insurance Company**
1425 Union Meeting Road
Blue Bell, PA 19422

☐ **Aetna Life Insurance Company**
151 Farmington Avenue
Hartford, CT 06156

Company name	**Requested effective date**
The requested effective date (may be the first or fifteenth of the month only). The actual effective date will be assigned by Aetna if this application is accepted. Do not cancel your current coverage until you receive written confirmation from Aetna that it accepted your application.	

Plan sponsor: Answer the following questions to the best of your knowledge and belief for all eligible employees and their dependents (proprietors, partners, corporate officers, employees, spouses, COBRA participants and dependent children). Give details to questions answered **yes** in the space provided.

Important: Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

1. Have any claims greater than $25,000 been paid in the last 12 months?	☐ Yes ☐ No
2. Are any employees or dependents pregnant? If **yes**, how many? _____	☐ Yes ☐ No
3. Has any employee missed 10 or more consecutive days of work in the past 12 months due to injury or illness?	☐ Yes ☐ No
4. Has the Group or broker/agent requested and/or received paid claim information within the past 6 months from your current carrier? If **yes**, provide all claim information received.	☐ Yes ☐ No
5. Within the past **12** months, has any employee or dependent had a serious continuing claim (i.e., chronic or ongoing condition likely to cost $10,000 or more per year for treatment) due to a mental or physical disorder? If **yes**, check the appropriate box(es) below.	☐ Yes ☐ No

a ☐ AIDS/Immune disorders
b. ☐ Alcohol abuse
c. ☐ Arthritis
d. ☐ Back/neck
e. ☐ Blood
f. ☐ Bone/joint
g. ☐ Brain
h. ☐ Cancer/tumor
i. ☐ Cardiovascular
j. ☐ Diabetes
k. ☐ Drug/substance abuse
l. ☐ Epilepsy
m. ☐ Ears/eyes
n. ☐ Emphysema/pulmonary
o. ☐ Heart disease
p. ☐ High risk pregnancies
q. ☐ Infertility
r. ☐ Intestines
s. ☐ Kidney
t. ☐ Liver
u. ☐ Lungs
v. ☐ Lupus
w. ☐ Mental/nervous
x. ☐ Migraines
y. ☐ Neurological
z. ☐ Pancreas
aa. ☐ Skin
bb. ☐ Stomach
cc. ☐ Stroke/paralysis
dd. ☐ Venereal
ee. ☐ Other (detail below)

If you answered yes to question 2, 3, 4 or 5, provide the following information for each individual with a likely serious continuing condition. Use additional sheet if necessary.

EE or Dep	Age	Site location	Nature of condition	Dates of treatment	Names of medication	$ Amount of prior claims	Prognosis/current treatment

Aetna Health Inc. underwrites Aetna HMO plans. Aetna Health Insurance Company underwrites the out-of-network components of the Aetna Health Network Option plans. Aetna Life Insurance Company underwrites Aetna Open Access EPO plans, Aetna PPO plans and Aetna Indemnity plans.

Aetna will rely on the information provided to determine whether a proposal will be issued. The responses are assumed to be correct. If errors or omissions are subsequently found, Aetna reserves the right to revise the group's rates or rescind the quote. Aetna will not use health status-related factors for the eligibility of any individual to enroll in a group plan.

FOR HMO PLANS: If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a marketing representative before signing this application.

Misrepresentation: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Prospective applicant name and title (please print)	***Prospective applicant signature*** **X**	***Date***
Agent signature (existing? ☐ Yes ☐ No) **X**	***Agent name (please print)***	***Date***