

This form is to be completed by the Employer/Owner or Authorized Company Officer.

Note: Medical claims may be reviewed for any individuals who had prior Aetna coverage.

Group Name		
To the best of your knowledge, answer the following questions for all enrollees including yourself, along with Partners, Officers, COBRA or State Continues and their dependents to be covered under this plan.		
1. How many employees enrolling for coverage have missed more than 10 consecutive days of work due to illness or injury in the past 12 months?		
2. Are any employees, dependents or COBRA continuees considered disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. How many employees enrolling for coverage have received Workers' Compensation, Social Security Income or Medicare in the past year?		
4. How many employees enrolling for coverage have received Disability Income in the past year?		
5. Has anyone had claims more than \$10,000 in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. How many enrollees are currently pregnant? C section planned <input type="checkbox"/> Yes <input type="checkbox"/> No Multiples Expected (# _____) Complications <input type="checkbox"/> Present <input type="checkbox"/> Past		
In the past 3 years has any enrollee been:		
8. Hospitalized or had a surgical procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Advised to have tests, surgery, hospitalization or is treatment needed or pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
In the past 3 years has any enrollee been diagnosed or treated for any of the following (check all that apply):		
10. <input type="checkbox"/> AIDS/ARC/HIV+ <input type="checkbox"/> Anxiety/Stress/Depression <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma/Emphysema/COPD <input type="checkbox"/> Back/Spine/Neck <input type="checkbox"/> Bipolar <input type="checkbox"/> Birth Defect/Congenital Abnormality <input type="checkbox"/> Blood Disorder/Hemophilia <input type="checkbox"/> Bones/Joints/Muscles <input type="checkbox"/> Brain <input type="checkbox"/> Cancer (Type: _____) <input type="checkbox"/> Surgery <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Carpal Tunnel <input type="checkbox"/> Central Nervous Disorder <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Circulatory Disorder <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Cleft Palate <input type="checkbox"/> Colitis <input type="checkbox"/> Connective Tissue Disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Ears/Eyes/Throat	<input type="checkbox"/> Eating Disorders <input type="checkbox"/> Emphysema/Pulmonary <input type="checkbox"/> Endocrine/Metabolic <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Gallbladder Disease <input type="checkbox"/> GERD <input type="checkbox"/> Growth Disorder <input type="checkbox"/> Heart Attack/Chest Pain <input type="checkbox"/> Heart Disorder/Disease <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Hepatitis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol/Triglycerides <input type="checkbox"/> Immune Disorder <input type="checkbox"/> Infertility <input type="checkbox"/> Intestine <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Kidney/Bladder/Urinary <input type="checkbox"/> Liver/Spleen/Pancreas <input type="checkbox"/> Lungs/Respiratory <input type="checkbox"/> Lupus <input type="checkbox"/> Mental/Emotional/Nervous	<input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Condition <input type="checkbox"/> Neurological <input type="checkbox"/> Nervous System <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pancreas <input type="checkbox"/> Paralysis <input type="checkbox"/> Pituitary/Adrenal <input type="checkbox"/> Pneumonia <input type="checkbox"/> Reproductive System <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Skin Disorder <input type="checkbox"/> Stomach/Esophagus/Digestion <input type="checkbox"/> Stroke <input type="checkbox"/> Substance Abuse (alcohol or drug) <input type="checkbox"/> Thyroid <input type="checkbox"/> Transplant: <input type="checkbox"/> Recommended <input type="checkbox"/> Pending <input type="checkbox"/> Complete <input type="checkbox"/> Tumor <input type="checkbox"/> Venereal <input type="checkbox"/> Other _____

continued on next page

Provide details to any "Yes" answers on Page 1. Use additional paper if necessary.

EE or Dep	Age	Condition	Treatment	\$ Amount of Claims	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)	Names of Medications	Current Status

I, as an Employer/Owner/Officer of this Company named above, who is responsible for the Company's benefit plan, certify to the best of my knowledge the information I have furnished is complete and accurate and includes all enrollees and dependents applying for coverage. I understand material misrepresentations or willful omissions may result in cancellation of insurance, non-renewal of coverage or a change in premium. If errors or omissions are subsequently found, Aetna Inc. reserves the right to revise rates or rescind the quote.

Employer/Owner/Officer Signature	Print Name	Title	Date (MM/DD/YYYY)
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NOTE: This form must be completed and signed by the employer, owner or officer of the company and is subject to review and approval by Aetna Underwriting.

Print Broker Name	Broker Signature	Date (MM/DD/YYYY)
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