



New York Individual Advantage Application

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

Aetna Health Inc. Use Only

Group Number _____	Effective Date _____
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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 () -

3. Type of Activity

<input type="checkbox"/> New Subscriber Effective Date _____	<input type="checkbox"/> Name Change From _____ Date of Event _____
<input type="checkbox"/> Add/Remove Dependent Reason _____ Date of Event _____	<input type="checkbox"/> Change of Primary <input type="checkbox"/> Withdrawal from Coverage Date of Event _____

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

5.	Change	Primary Office No.
a.	<input type="checkbox"/>	
b.	<input type="checkbox"/>	
c.	<input type="checkbox"/>	
d.	<input type="checkbox"/>	
e.	<input type="checkbox"/>	
f.	<input type="checkbox"/>	

Physicians' offices must be in the state in which you reside.

6. Dependent Information

Do any of the dependents listed in #4 Yes No live at another address?
If Yes, who and at what address?

Explain the circumstances:

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

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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). <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please give name and policy number of other insurance carrier or type of coverage. Are other family members eligible for coverage? If Yes, specify. <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you replacing existing coverage? <input type="checkbox"/> Yes <input type="checkbox"/> 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, 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 advise, 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. In addition, this exclusion shall not apply to an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under Creditable Coverage. Also, this exclusion shall not apply to a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under Creditable Coverage.

I acknowledge that I have read and understand the above.

Subscriber Signature _____

9. Subscriber Signature

Subscriber E-mail Address:

I certify that 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 applicant 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.

Subscriber Signature _____	Date _____
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Full monthly payment must accompany this application. Make check payable to Aetna Health Inc. Boxes 8 and 9 must have applicant's signature for application to be processed.
Application is not proof of coverage.

Individual Application Instructions

Complete all Sections if you are:

1. Enrolling as a new subscriber
2. Changing dependent coverage

Complete Sections 2, 3, 4, 5 and 9 if you are changing a provider.

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

Conditions of Enrollment

Applicant 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 unmarried children under 19 years of age and unmarried children between the ages of 19 and 23 who are full-time students at an accredited educational institution and neither my spouse nor children are eligible for group health benefits coverage.
3. 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.
4. 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.
5. I agree to make directly to providers of health care such copayments as are provided for in the Individual Contract.
6. 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.
7. 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.
8. 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.
9. 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 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.