aetna®

Application

Medicare Supplement Insurance

Underwritten by

Aetna Health and Life Insurance Company

New Hampshire

aetnaseniorproducts.com

AHLMS04432NH

091018

aetna®

Aetna Health and Life Insurance Company

Administrative Office
800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067

Application for Medicare Supplement Insurance
from Aetna Health and Life Insurance Company

- Print clearly and use blue or black ink.
- If only one applicant, just complete **Applicant A** information.
- Complete all required sections of the application. Any incomplete or missing information could delay processing of your application.

1. Applicant A information

Write the name as stated on the Medicare card. Provide a copy of the Medicare card with the application if possible.

Full name of proposed insured *First, M.I., Last*

Phone

Residential address

Apt/suite number

City

State

Zip

Write your mailing address if different from your residential address.

Mailing address

Apt/suite number

City

State

Zip

E-mail

Social Security Number

Write the date of birth that is on the birth certificate.

Birth date *mm/dd/yyyy*

Age

○ Male ○ Female

Are you a legal resident of the United States?

○ Yes ○ No

Include any letters associated with the Medicare number and in the appropriate position. If applicant has not received a Medicare card yet, put "No Medicare number yet".

Medicare card number

Date enrolled in: Medicare Part A

Medicare Part B

Applicant B information

Review instructions above before completing.

Full name of proposed insured *First, M.I., Last*

Phone

Residential address

Apt/suite number

City

State

Zip

Mailing address

Apt/suite number

City

State

Zip

E-mail

Social Security Number

Birth date *mm/dd/yyyy*

Age

○ Male ○ Female

Are you a legal resident of the United States?

○ Yes ○ No

Medicare card number

Date enrolled in: Medicare Part A

Medicare Part B

For Agent Use Only

Check if application is for:

Applicant A

○ Open Enrollment
○ Guaranteed Issue

Applicant B

○ Open Enrollment
○ Guaranteed Issue

Mail policy(ies) to:

○ Agent ○ Applicant(s)

Applicant A Initials _____ Applicant B Initials _____

2. Plan and premium information

You have a choice among several payment options or modes for paying your premium (annual, semi-annual, quarterly and monthly electronic funds transfer).

If applying for household discount: provide the discounted and non-discounted premium amounts.

Household premium discount eligibility information

To be eligible for the household discount as outlined below, please answer the applicable eligibility questions in this section.

1) Is the other Medicare eligible adult applying either:
a. your spouse; or
b. someone with whom you are in a civil union partnership; and
c. someone with whom you have continuously resided for the past 12 months?

Applicant A ○ Yes ○ No
Applicant B ○ Yes ○ No

If both answered "yes" and purchase this policy, you will qualify for the household premium discount.

2) Or, does the other Medicare eligible adult already have Medicare supplement coverage with the same or another Aetna Company that also has available a household discount and is either:
a. your spouse; or
b. someone with whom you are in a civil union partnership; and
c. someone with whom you have continuously resided with for the past 12 months?

Applicant ○ Yes ○ No

If yes, please provide the following information:

Name: _____

Address: _____

_____

Policy Number: _____

Upon verification of eligibility and approval of your application, you and the existing policyholder will qualify for the discount.

Applicant A
Plan selected:
.
Requested Medicare Supplement effective date: *mm/dd/yyyy*
.
Modal premium:
$
Payment mode: ○ Annually ○ Quarterly ○ Semi-Annually ○ Monthly EFT (Electronic Funds Transfer)
Modal premium with discount:
$
Payment method
○ Check ○ EFT
○ List Bill billing file identifier _____
Application fee:
$
Total initial premium collected/draft:
$
Initial premium:
○ Draft initial premium upon policy approval
○ Draft initial premium on policy effective date

Applicant B
Plan selected:
.
Requested Medicare Supplement effective date: *mm/dd/yyyy*
.
Modal premium:
$
Payment mode: ○ Annually ○ Quarterly ○ Semi-Annually ○ Monthly EFT (Electronic Funds Transfer)
Modal premium with discount:
$
Payment method
○ Check ○ EFT
○ List Bill billing file identifier _____
Application fee:
$
Total initial premium collected/draft:
$
Initial premium:
○ Draft initial premium upon policy approval
○ Draft initial premium on policy effective date

HOUSEHOLD PREMIUM DISCOUNT INFORMATION

In order to be eligible for the household discount under an Aetna Health and Life Insurance Company Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by an Aetna Company policy. The Medicare eligible adult must be either: (a) your spouse; (b) someone with whom you are in a civil union partnership; and (c) someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rates will be 7 percent lower than the individual rates and will apply as long as both policies remain in force.

PAYMENT MODES

Each payment mode, other than annual and monthly electronic funds transfer, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations and lapse rates. The annual and monthly electronic funds transfer modes have the same and lowest total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You may change your payment mode, among the modes available, during the life of your policy.

Application for Medicare Supplement Insurance

Applicant A Initials_____ Applicant B Initials_____

3. Eligibility questions

Please answer all questions.

To the best of your knowledge:	Applicant: A	B
1. Did you turn age 65 in the last 6 months?	OY ON	OY ON
A. Did you enroll in Medicare Part B in the last 6 months?	OY ON	OY ON
B. If yes, what is the effective date?		
Applicant A effective date . / /		
Applicant B effective date . / /		
2. Are you covered for medical assistance through the state Medicaid program?	OY ON	OY ON
A. If yes: Will Medicaid pay your premiums for this Medicare Supplement policy?	OY ON	OY ON
B. Do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium?	OY ON	OY ON
3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "End" blank.		
Applicant A start date . / / End date . / /		
Applicant B start date . / / End date . / /		
A. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	OY ON	OY ON
B. Was this your first time in this type of Medicare plan?	OY ON	OY ON
C. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?	OY ON	OY ON
4. Do you have another Medicare Supplement policy inforce?	OY ON	OY ON
A. If so for **Applicant A**, with what company, and what plan do you have? Company . Plan .		
If so for **Applicant B**, with what company, and what plan do you have? Company . Plan .		
B. If so, do you intend to replace your current Medicare Supplement policy with this policy?	OY ON	OY ON
5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)	OY ON	OY ON
A. If so for **Applicant A**, with what company, and what kind of policy? Company . Plan .		
B. What are your start and end dates of coverage under the other policy? (If you are still covered under the other policy, leave "End" blank.) Start date . / / End date . / /		
A. If so for **Applicant B**, with what company, and what kind of policy? Company . Plan .		
B. What are your start and end dates of coverage under the other policy? (If you are still covered under the other policy, leave "End" blank.) Start date . / / End date . / /		

NOTE: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to question 2.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

Applicant A Initials _____ Applicant B Initials _____

4. Health questions

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

If the health questions are answered for an Open Enrollment or Guaranteed Issue application, the application cannot be processed and will be returned.

Answer these questions only if you are applying for underwritten coverage.

Applicant:	A	B
1. Are you dependent on a wheelchair or any motorized mobility device?	OY ON	OY ON
2. Do any of the following apply to you?		
Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy	OY ON	OY ON
3. At any time, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. congestive heart failure, unoperated aneurysm, defibrillator	OY ON	OY ON
B. leukemia, lymphoma, multiple myeloma, cirrhosis	OY ON	OY ON
C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy	OY ON	OY ON
D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease	OY ON	OY ON
E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant	OY ON	OY ON
F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV)	OY ON	OY ON
4. Have you been medically diagnosed or treated by a member of the medical profession for diabetes?		
A. that requires use of insulin	OY ON	OY ON
B. with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage	OY ON	OY ON
C. with history of heart attack or stroke (at any time)	OY ON	OY ON
D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar	OY ON	OY ON
5. Within the past 36 months, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. alcoholism, drug abuse	OY ON	OY ON
B. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder	OY ON	OY ON
C. internal cancer, melanoma, Hodgkin's Disease	OY ON	OY ON
D. hepatitis, disorder of the pancreas	OY ON	OY ON
6. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease	OY ON	OY ON
B. myasthenia gravis, systemic lupus or connective tissue disorder	OY ON	OY ON
C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living	OY ON	OY ON
D. any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder	OY ON	OY ON
E. any lung or respiratory disorder and currently use tobacco products	OY ON	OY ON
7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or surgery that has not been performed or do you have pending test results?	OY ON	OY ON
8. Within the past 12 months, have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder?	OY ON	OY ON
9. Within the past 12 months, have you been medically diagnosed with wet macular degeneration and have taken or are currently receiving injections?	OY ON	OY ON

Health questions *continued*

Systolic is the upper number and Diastolic is the bottom number of a blood pressure reading.

A "yes" answer to question 12 will not disqualify you for this insurance with us.

	Applicant: A	B
10. Within the past 12 months, do any of the following apply to you? A. had a pacemaker implanted	OY ON	OY ON
B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer	OY ON	OY ON
C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer	OY ON	OY ON
D. had a seizure	OY ON	OY ON
11. Was your last blood pressure reading higher than 175 Systolic or higher than 100 Diastolic?	OY ON	OY ON
12. Have you used any form of tobacco in the past 12 months?	OY ON	OY ON

13. Height *Feet and inches* — **Applicant A** _____ **Applicant B** _____
Weight *Pounds* — **Applicant A** _____ **Applicant B** _____

5. Applicant A health history

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

1. Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:

2. Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:

3. **Describe the medications you are taking and why.**

Use an additional sheet of paper if needed for explanation.

Applicant B health history

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

1. Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:

2. Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:

3. **Describe the medications you are taking and why.**

Use an additional sheet of paper if needed for explanation.

6. Applicant A physician information

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

Your primary physician Phone

Physician's office name

City State

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Have you seen any additional physicians other than those listed above in the past 24 months? ○ Y ○ N

Applicant B physician information

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

Your primary physician Phone

Physician's office name

City State

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Have you seen any additional physicians other than those listed above in the past 24 months? ○ Y ○ N

7. Important statements

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
6. 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, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

8. Privacy notice

Although your application is our initial source of information, we may collect information, including health history and medical records, from persons other than you and we may conduct a telephone interview with you. Aetna Health and Life Insurance Company, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures.

9. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our companies, or for the percentage of completed sales. Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

10. Applicant(s) agreement

This agreement is to acknowledge that I am applying for an insurance policy from Aetna Health and Life Insurance Company that will be issued based on my answers to the questions on this application. I have read, or had read to me, and understand all statements and answers and acknowledge that to the best of my knowledge and belief, they are all accurate, complete and correctly documented. I understand that I will receive a copy of the signed application. I acknowledge that I have received an outline of coverage for the policy that I applied for, along with a copy of Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.

I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that upon acceptance of the completed application, each applicant will receive a separate policy with a copy of this application attached.

I understand and agree that this application and any policy issued will be the entire contract of insurance. The Company will not be bound by any statements, promises, or information made or given by any agent or other person at any time unless it is in writing, submitted to the Company's home office, and made a part of the contract of insurance. An Officer of the Company is the only one who can make, modify or discharge contracts or waive any of the Company's rights or requirements; and any modifications must be documented in writing.

I also understand and agree that this application will not be approved until the first premium is paid, there has been no change in my health as stated in the application, and a policy has been issued by the Company.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

I understand that if any answers on this application are incorrect, incomplete or untrue, Aetna Health and Life Insurance Company has the right to adjust my premium, or cancel this policy.

Applicant A signature

X _____

Date signed

_____

Applicant B signature

X _____

Date signed

_____

NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of 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 subjects such person to criminal and civil penalties.

11. Applicant A account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Draft date cannot be on the 29th, 30th or 31st of the month. Requesting to have a draft date more than 10 days greater than the policy's paid to date will draft a month in advance.

Name

Account owner name, if different than proposed insured's

Account owner relationship to proposed insured: ○ Business owned by proposed insured ○ Living trust ○ Employer ○ Power of Attorney ○ Conservator/guardian ○ Family member; specify

Financial institution name

○ Checking ○ Savings

Routing number

Account number

Draft date if different from effective date

Applicant B account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Draft date cannot be on the 29th, 30th or 31st of the month. Requesting to have a draft date more than 10 days greater than the policy's paid to date will draft a month in advance.

Name

Account owner name, if different than proposed insured's

Account owner relationship to proposed insured: ○ Business owned by proposed insured ○ Living trust ○ Employer ○ Power of Attorney ○ Conservator/guardian ○ Family member; specify

Financial institution name

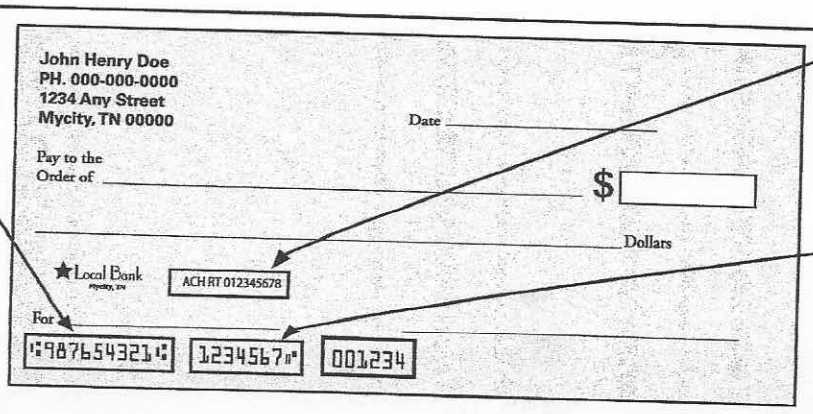
○ Checking ○ Savings

Routing number

Account number

Draft date if different from effective date

This is an example of a personal check. A business check may be different.



For all other checks, use the nine-character bank **routing number**, which appears between the ⑆ symbols, usually at the bottom left corner of the check.

For checks with an **ACH RT (Automated Clearing House Routing) number**, please use this numb

The **account numbe** is up to 17 characters long and appears nex to the ⑈ symbol at th bottom of the check and usually to the righ of the bank routing number.

12. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Signature of account owner for **Applicant A** Date

X . .

Signature of account owner for **Applicant B** Date

X . .

13. Agent

All information **must** be completed.

Please list any other medical or health insurance policies sold to **Applicant A**.

1) List policies sold which are still in force

. .

2) List policies sold in the past 5 years which are no longer in force

. .

Please list any other medical or health insurance policies sold to **Applicant B**.

1) List policies sold which are still in force

. .

2) List policies sold in the past 5 years which are no longer in force

. .

I certify that:

1. I have truly and accurately recorded the information supplied by the applicant(s).
2. The application was provided to the applicant(s) to review and the applicant(s) has been advised that any false statement or misrepresentation in the application may result in an adjustment of premium, reduction of benefits or rescission of the policy(ies).
3. I have provided an outline of coverage for the policy(ies) applied for and *A Guide to Health Insurance for People with Medicare* to applicant(s) prior to completing the application.

Agent name *Printed*: Thomas Buonanduci

Writing number (agent or company): GNW2005421

The writing number reflects where commissions will be paid.

Agent signature: X

State license ID number (for FL only): .

Phone: (603)622-5700

E-mail: HealthPlanSavings@Comcast.net

14. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through Aetna Health and Life Insurance Company (AHLIC), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with AHLIC in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains inforce.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective AHLIC commission schedule.

Agent Information *Print*

Writing Agent

Percentage

Secondary Agent | Writing number | Percentage

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Writing Agent Signature

X

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Aetna Health and Life Insurance Company

Administrative Office
800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067

Health Information Authorization
from Aetna Health and Life Insurance Company

- Print clearly and use blue or black ink.
- This is a HIPAA Compliant Authorization.

To Agent: Have applicant complete and sign home office copy to submit with application. Applicant keeps one copy.

Applicant declarations

Please read these statements carefully

I authorize the use and disclosure of health information about me as described herein.

Health Information to be Used or Disclosed: This Authorization applies to information about: my past, present, or future physical or mental health or condition; health care I receive; the past, present, or future payment for my health care; and any related diagnosis, treatment, or prognosis. This includes, but is not limited to, information about: drugs; alcoholism and mental illness; and may be in electronic or paper form. It does not include information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC.

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: Aetna Health and Life Insurance Company; its insurance support organizations; its affiliates and reinsurers.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: physicians; health professionals; hospitals; clinics; the Veterans Administration; or other medical or medically related facilities; care providers or evaluators; insurance companies; reinsurers; insurance support organizations.

Purpose: This health information may be used or disclosed to: evaluate and underwrite my application; determine premium amounts, adjudicate claims and to support the operations of our health plans.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization; and that a copy of it is as valid as the original; (2) this Authorization will be valid for 24 months from the date signed; (3) if I do not sign this Authorization, or revoke it by writing to Aetna Health and Life Insurance Company at its Administrative Office, the Company may decline my application; and (4) If I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization (5) Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Primary applicant please fill in this information

Signature of applicant

X

Date

Printed name of applicant

X

City

State

Zip