PA Insurance Services
1744 DeKalb Pike #141
Blue Bell, PA 19422
(717) 720-8040
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Drew Bucaro
HEALTH ·DENTAL ·LIFE · DISABILITY
401K · RETIREMENTS · ANNUITIES

Instructions

Complete application (personal information only) and sign all designated places. Return with first month's premium made out to "Aetna". Also include a "Void" check if paying by monthly bank draft (electronic funds transfer). Return to above address.

You may receive a telephone verification in approximately 7-10 days. Please call back if you miss this call. I will contact you shortly after with a status report or approval.

The plan takes approximately 3-6 weeks to start. **Please do not cancel your current plan.**

Plan Details

The directory of providers is located at www.aetna.com Hit Provider finder (HMO network). You can also contact the billing person at your doctors office to verify that they accept the plan.

The HMO plans require referrals for specialist and the Open Access 10 offers direct access to any Aetna doctor in the USA.

Call to go over anything that is not clear

Agency Details

PA Insurance Services is a full service Health and Life Agency. We represent all the top carriers in Health and Life and shop for the client. We want happy clients who can get affordable & adequate coverage. We represent you the client, not the insurance company!

We offer other alternatives in PA. Please contact us for comparison quotes from all available carriers.

Individual Advantage Program - PA

Application and Enrollment/Change Form

Applicant's Social Security Number

Instructions:

- Application must be completed by the applicant in blue or black ink.
- This application/enrollment form must be completed in its entirety and first month's premium check enclosed or processing time will be delayed.
- Signature is required on Page 4, Section M for all applicants including spouse and children over the age of 18.
- Any family member currently pregnant (whether or not listed on this application) or in the process of adoption or surrogacy does not qualify for this program.

A. Applicant Information

Name	Choose desired benefit plan type:	Reason for Application
Home Address (Required) - Include Apartment Number, if applicable. Number, Street ______ City, State, ZIP Code ______	☐ Open Access HMO 10 ☐ HMO 15 ☐ HMO 20	☐ New Enrollment ☐ Add Spouse/Dependent Child ☐ Add Dependent Child Only ☐ Change Existing Benefit Plan

Telephone Numbers	Marital Status	Provide Name and Address of applicant's employer. (Required, if applicable)
Home ( ) - Work ( ) -	☐ Single ☐ Married	

E-mail Address (optional)	Primary Language Spoken (optional)	Occupation	Date of Hire

Has any person listed on this application resided outside the U.S. for the past six (6) consecutive months? ☐ Yes ☐ No If "Yes", please provide name and explain.

B. Individuals Covered/Physician Selection

(Dependent children are covered up to age 19; and between the ages of 19 through 22 with proof of full-time student status.)

Family Code	Name (Last / First / M.I.)	Social Security Number	Date of Birth (MM / DD / YYYY)	Age	Sex (M/F)	Full-time Student Age 19 or Older	Height (ft / in)	Weight (lbs)	Provider Office Number *
APP	Applicant					Yes N/A			
SP	Spouse					N/A			
01	Dependent					☐			
02	Dependent					☐			
03	Dependent					☐			

*** Visit our website (www.aetna.com/DocFind) to request a paper directory to choose your Pennsylvania Primary Care Physician(s) - Use "Office No." listed in Directory or DocFind®.**

If more space is needed to provide information for additional dependents, check here ☐ and use a separate sheet of paper. Please staple to the back of this enrollment form.

C. Dependent Information

Do you claim all children listed above who are between the ages of 19 through 22 as dependents on your Federal Income Tax? ☐ Yes ☐ No	If "NO", any child between the ages of 19 through 22 who is not claimed on your Federal Income Tax is NOT eligible as a dependent but may apply individually.

D. 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.)	Family Code	
APP	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ______	01	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ______
SP	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ______	02	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ______
		03	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 ______

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

Are you replacing existing coverage? ☐ Yes ☐ No Do you currently have any health care coverage? ☐ Yes ☐ No Are your spouse/children covered also? ☐ Yes ☐ No	Are any family members currently enrolled in the PA Individual Advantage Program? If Yes, provide names and relationship. ☐ Yes ☐ No Provide name of current (or most recent) health care carrier and coverage termination date (if applicable).	Are you/your dependent(s) eligible for Medicare? ☐ Yes ☐ No If Yes, provide: Name: ______ Eligibility Date: ______	Has any applicant ever been eligible for or received benefits from disability insurance or Workmen's Compensation? If Yes, provide dates and details. ☐ Yes ☐ No

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

If Aetna approves my application, please assign an effective date of the ☐ 1st or the ☐ 15th of ______. This date must be no later than 90 days after the signature date (Page 4, Section M) of this application. This date will be honored provided that Aetna's approval is within 30 days of the requested effective date. If no effective date is requested, Aetna will assign an effective date of the 1st or the 15th of the month following the approval date of my application.	**Aetna Use Only Y - N - U** Group Number: Effective Date:

This application and enrollment/change form is not proof of coverage.

Applicant's Social Security Number

G. Health History for Individuals and Their Dependents *(Include information for all persons applying for coverage.)*

Answer all questions & provide complete details to all "yes" answers on Page 3, Section I. **Missing information may delay processing this application.**

In the past ten (10) years, has any person listed on this application consulted a health care provider, received treatment (including prescription medications) or been hospitalized for any of the following conditions or diseases?

G1.	**Eyes, Ears, Nose and Throat:** *Eyes/sight:* glaucoma, cataracts, crossed eyes, detached retina, infections; *Ears/Hearing:* loss of hearing, deafness, infections, eustachian tube dysfunction; *Nose/breathing:* deviated septum, polyps, adenoiditis, sinusitis; *Throat/Swallowing:* tonsillitis, strep throat, excessive snoring or sleep apnea, etc?	☐ Yes ☐ No
G2.	**Skin Conditions/Disorders:** Acne, birthmarks, dermatitis, eczema, fungal infections, psoriasis, keratosis, warts, moles, pre-cancerous lesions, skin cancer or melanoma, etc?	☐ Yes ☐ No
G3.	**Musculoskeletal Conditions/Disorders:** Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as strain/sprain, fracture, arthritis, gout, herniated disc, joint replacement, internal fixations, permanent hardware, amputation/prosthesis, etc?	☐ Yes ☐ No
G4.	**Respiratory Conditions/Disorders:** Allergies, sinusitis, bronchitis, asthma, pneumonia, shortness of breath, chronic cough, pneumothorax, emphysema, tuberculosis, fungal infections, etc.?	☐ Yes ☐ No
G5.	**Digestive Conditions/Disorders:** Infections of mouth/throat/tonsils; problems with jaw or chewing; ulcers, hernia, gastric influx, colitis, chronic diarrhea, intestinal problems; colon polyps, rectal bleeding or hemorrhoids; diseases of the pancreas, liver or gallbladder; hepatitis B/C, jaundice, unexplained weight loss or gain?	☐ Yes ☐ No
G6.	**Urinary Conditions/Disorders:** Bladder infections, kidney infections, stones, blood in urine, incontinence, etc.?	☐ Yes ☐ No
G7.	**Heart and Circulatory Conditions/Disorders:** Anemia, bleeding/clotting disorders; varicose veins, Raynauds, phlebitis, thrombosis; enlarged lymph nodes or lymphadenitis; chest pain, angina, high/low blood pressure, hypertension, high cholesterol, heart murmur, palpitations, congestive heart failure, coronary artery disease, aneurysm, heart attack; bypass surgery/angioplasty, valve replacement, pacemaker or defibrillator, etc.?	☐ Yes ☐ No
G8.	**Metabolic and Endocrine Conditions/Disorders:** Diabetes, adrenal/pituitary disorders; lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis; thyroid disorders, immune disorders; AIDS/ARC, etc.?	☐ Yes ☐ No
G9.	**Brain/Nervous System Conditions/Disorders:** Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, confusion, memory loss, head injury, stroke; migraine headaches or chronic/severe headaches; narcolepsy, sleep apnea, tremors; multiple sclerosis, etc.?	☐ Yes ☐ No
G10.	**Male Reproductive Conditions/Disorders:** Infertility, low sperm count, sexual dysfunction, enlarged prostate, prostatitis, undescended testes; genital herpes/warts or sexually transmitted diseases, etc.?	☐ Yes ☐ No
G11.	**Female Reproductive Conditions/Disorders:** Pelvic pain, abnormal menstrual bleeding, absence of menstruation; endometriosis, ovarian cysts, uterine fibroids, infertility, miscarriage; breast cysts/lumps/fibroids; genital warts/herpes or sexually transmitted diseases, etc. ?	☐ Yes ☐ No
G12.	**Provide the date and result of last Pelvic Exam/Pap Smear for each female over age 16:** Name: ________ Date: ______ Result: Normal ☐ Abnormal ☐ Name: ________ Date: ______ Result: Normal ☐ Abnormal ☐ Name: ________ Date: ______ Result: Normal ☐ Abnormal ☐	
G13.	**Nervous, Mental and Behavioral:** Depression, anxiety, attention deficit, chemical imbalance; bi-polar, obsessive-compulsive or panic disorders; substance abuse, eating disorders; counseling or support group?	☐ Yes ☐ No
G14.	**Cancer/Tumors:** Cysts, tumors or abnormal growths; Hodgkin's disease, leukemia or any other cancer?	☐ Yes ☐ No
G15.	**Birth Defects/Congenital Abnormalities:** Birthmarks, cleft palate/lip, club foot, webbed fingers/toes; developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation; skull or facial deformities; Cerebral Palsy?	☐ Yes ☐ No
G16.	**Other Conditions:** Has any applicant consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s) not listed on this application?	☐ Yes ☐ No

NOTE: Medical conditions that occur after the signature date but prior to underwriting approval will be considered in the final underwriting decision.

H. Health Related Questions *(Include information for all persons applying for coverage.)*

Answer all questions & provide complete details to all "yes" answers on Page 3, Section I. **Missing information may delay processing this application.**

H1.	Is any ***female*** applicant pregnant or in the process of adoption or becoming a surrogate? If Yes, provide applicant name below. Applicant Name: ________	☐ Yes ☐ No
H2.	Is any ***male*** applicant expecting a child or in the process of adoption or surrogacy with anyone whether or not that person is applying for coverage on this application? If Yes, provide applicant name below. Applicant Name: ________	☐ Yes ☐ No
H3.	Has any applicant been medically treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? If Yes, provide applicant name(s) below. Applicant Name: ________ Applicant Name: ________	☐ Yes ☐ No
H4.	Has any applicant used controlled substances including LSD, marijuana, heroin, cocaine or methamphetamines? If Yes, provide information below. Applicant Name: ________ Substance: ______ Date Stopped ______ Applicant Name: ________ Substance: ______ Date Stopped ______	☐ Yes ☐ No
H5.	Has any applicant had any ***abnormal*** lab results, X-rays, MRI or other diagnostic test results or physical exam results?	☐ Yes ☐ No
H6.	Has any applicant been medically advised to undergo further medical testing, treatment or surgery which has not yet been completed?	☐ Yes ☐ No
H7.	Has any applicant been a patient in a clinic, hospital, surgical center, treatment center or other medical facility in the last 10 years?	☐ Yes ☐ No
H8.	Has any applicant seen any health care provider for any condition, signs or symptoms which have not yet been diagnosed?	☐ Yes ☐ No
H9.	Has any applicant smoked or used tobacco in the last 2 years? If Yes, provide applicant name(s) below. Applicant Name: ________ Date Stopped ______ Applicant Name: ________ Date Stopped ______	☐ Yes ☐ No
H10.	Has any applicant taken prescription medications or been advised to take prescription medications in the last 2 years?	☐ Yes ☐ No

Applicant's Social Security Number

I. Detailed Health Information

If additional space is needed, check here ☐ and use a separate sheet of paper. Please staple to the back of this enrollment form.

1. Provide COMPLETE DETAILS to ALL questions answered "Yes" in Sections G and H.

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

2. List all medications taken by you and/or your named dependents within the last 12 months.

Family Code*	Ques. No.	Dates From/To	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 dependents consulted. If none, please state "None."

Family Code*	Question Number and/or Reason	Name, Address and Phone Number of Attending Physician(s)

4. List last doctor visit for all family members, including routine check-ups.

Family Code*	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.**

J. Important Subscriber Information

Please Read Carefully

1. **Send a check payable to "AETNA" for one month's premium with your completed application. A business check from a sole proprietor will be accepted only if accompanied by the applicant's Schedule C or 1099 miscellaneous form.** A 1099 Interest form, 1099 Dividend, and others do not apply and will not be accepted.
2. Coverage may be denied, or a premium adjustment made, based on information provided to Aetna during the application process. In the case of denial, you will receive a letter notifying you that your application has not been accepted. Aetna is not required by law to provide further explanation for the denial; therefore, all details will be kept confidential. If applicant is denied coverage, the original check will be returned directly to the applicant.
3. Do ***not*** cancel other coverage presently in force until written notification is received from Aetna indicating that your application has been approved and you and covered dependents are in receipt of your member ID card(s) providing the effective date of coverage.

K. Easy Pay

☐ **Yes**, I would like to use Easy Pay. Checking Account Number: ____________ Name of Bank: ____________

Name(s) on Checking Account: ____________

Please include a blank check marked "VOID" showing the preprinted account number in addition to the first month's premium check.

☐ **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, the 1st of every month. I understand that by checking the "Yes" box above and with my application signature on Page 4 (Section M) I am accepting the terms of the Easy Pay Agreement.

NOTE: Terms and conditions of Aetna's Group Agreement shall remain in full force and effect. 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 4, Section M) even if not applying.

Applicant's Social Security Number

L. Declaration **Please Read Before Signing Below**

By applying for coverage for myself and the dependents listed in Section A, I agree to/with the following:

1. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. If you are terminated for nonpayment of premium, you **may** no longer be eligible to enroll in the PA Individual Advantage Program.
2. As a condition of coverage, I understand and agree that (with the exception of emergency procedures and certain direct access services as defined in the plan documents) all services, in order to be covered by Aetna, must be performed either by a participating Pennsylvania primary care physician, or by the participating specialist, hospital, pharmacy (if applicable) or other provider as authorized by a referral from a participating primary care physician.*
   ** Some services may require prior authorization from Aetna.*
3. I authorize Aetna to coordinate benefits under this policy with other individual coverage I or any covered dependent have which is subject to coordination.
4. I agree to make copayments, as provided for in my plan documents, directly to providers of health care.
5. Aetna (including its affiliates and authorized agents, collectively "Aetna") and participating network providers require access to member medical information for a number of purposes, including claims payment and fraud prevention; preventive health, early detection and disease management programs; coordination of patient care; quality improvement/management/assessment; utilization review and management; fulfilling state and federal requirements; HEDIS and similar data collection and reporting; accreditation by the National Committee for Quality Assurance and other accreditation organizations; and statistical research. Accordingly, I authorize the sharing of member medical information about myself and my dependents between Aetna and any hospital, physician, or other health care provider or health delivery system as Aetna and such participating providers may require. It is the policy of Aetna to protect the confidentiality of my confidential medical information to the full extent required by law. I know that I, or an individual entitled to act on my behalf, am entitled to receive a copy of this authorization upon request and agree that a photocopy is as valid as the original.
6. The plan documents will determine the rights and responsibilities of member and will govern in the event they conflict with any benefits comparison, summary, or other descriptions of the benefit plan.
7. I represent that the statements and answers given in this application are true, complete and correctly recorded to the best of my knowledge and belief and that any material misrepresentation may be reason to cancel this policy.
8. I understand that this coverage will remain in effect until written cancellation notice is received by Aetna regardless of the continued availability of a particular primary care physician or other health care provider.
9. 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.
10. I agree that this authorization shall be valid without time limit.
11. 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.

M. Signature(s) Required - **All applicants over the age of 18 must sign and date below. If applicant is a minor, the application must be signed by a parent or legal guardian.**

I acknowledge that I have read and understand ALL statements above. I verify that I have thoroughly answered ALL questions and have indicated my benefit plan selection. I UNDERSTAND THAT IF MY SIGNATURE/DATE DO NOT APPEAR AND/OR MY ANSWERS ARE INCOMPLETE, my application will either be denied or returned for completion (at the discretion of Aetna).

Applicant/Parent or Legal Guardian Signature	Date	Applicant Spouse (if applying for coverage)	Date
Applicant's Dependent Age 18 or Older Signature	Date	Applicant's Dependent Age 18 or Older Signature	Date

N. Statement of Accountability - **To be completed if the applicant cannot or has not completed the application.**

I, ______________________________, personally read and completed the Individual Enrollment Application for the applicant because: ______________________________ Relationship to Applicant: ______________

O. To Be Completed by your Aetna-Appointed Agent **(If applicable)**

1. Are you aware of any information not disclosed on this application relating to the health, habits or reputation of any person listed on this application which might have a bearing on the risk? If yes, please attach explanation. ☐ Yes ☐ No
2. Did you see the proposed subscriber (and spouse, if applying) at the time this application was executed? If no, please explain. ☐ Yes ☐ No

Signature of Agent (Required)		Date	E-mail Address
[signature]			mark@insurancepa.com
Name of Agent (print name): Mark Teitelman	% of Credit	Agent Street Address: 1744 DeKalb Pike	Suite No. / Personal Mail Box (PMB) No.: #141
Telephone Number: (215) 699-4052	FAX Number: (801) 912-7959	City / State / ZIP Code: Blue Bell, PA 19422	
Signature of Secondary Broker (Required, if applicable)		Date	E-mail Address
Name of Secondary Broker (print name)	% of Credit	Secondary Broker Street Address	Suite No. / Personal Mail Box (PMB) No.
Telephone Number	FAX Number	City / State / ZIP Code	