Click to Print

Home

Simple Instructions

1. Print and complete the application

2. Include a check for one month's premium

3. Mail your application to:

For free postage, cut and paste this label onto your envelope.

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 679 NORTHRIDGE, CA

POSTAGE WILL BE PAID BY ADDRESSEE

HEALTH AND LIFE INSURANCE SERVICES
APPLICATION PROCESSING CENTER
9510 SYLVIA AVENUE
NORTHRIDGE, CA 91324-9904

Questions? Call: 1-800-243-8100

Aetna Medicare

Aetna Individual Medicare Supplement Plan Application
Aetna Life Insurance Company
For California Residents Only

Fax to: 1-800-501-9222

1 APPLICANT INFORMATION (Proposed Policyholder) – Please Print

Last Name	First Name	MI

Social Security Number	☐ Male ☐ Female	Birth Date *(MM/DD/YYYY)*

Street Address (Number, Street, Apt.)

City	State	ZIP Code	County

Billing Address (if different from above)

Telephone Number ( )	Primary Language Spoken (optional)

Email Address (optional)

2 MEDICARE INFORMATION – Please fill out this information exactly as it appears on your Medicare card.

MEDICARE ● HEALTH INSURANCE

CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER

_____ – _____ – _____

IS ENTITLED	EFFECTIVE DATE
HOSPITAL (PART A)	
MEDICAL (PART B)	

3 "NOTICE OF POLICY LAPSE" ADDRESSEE INFORMATION – In addition to the policyholder, a copy of any notification of possible lapse will be sent to the person listed below. (Please note that **this person should not reside at the same address as the policyholder.)**

Name: _____

Address: _____

4 MEDICAL AND GENERAL (A telephone interview with the applicant may be conducted to verify application)

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. PLEASE ANSWER ALL QUESTIONS.

Please Mark **Yes** or **No** with an "X"

To the best of your knowledge,

(1) Did you turn age 65 in the last 6-months? ..... ☐ Yes ☐ No

(a) Did you enroll in Medicare Part B in the last 6-months? ..... ☐ Yes ☐ No

(b) **IF YES**, what is the effective date? _____

(c) If you are under age 65, have you been diagnosed with or treated for End-Stage Renal Disease (ESRD)? ..... ☐ Yes ☐ No

(2) Are you covered for medical assistance through the state Medi-Cal program? ..... ☐ Yes ☐ No

(**NOTE TO APPLICANT:** If you have a "Share of Cost" under the Medi-Cal program, please answer **NO** to this question.)

IF YES,

(a) Will Medi-Cal pay your premiums for this Medicare supplement policy? ..... ☐ Yes ☐ No

(b) Do you receive any benefits from Medi-Cal OTHER THAN payments towards your Medicare Part B premium? ..... ☐ Yes ☐ No

continued

PLEASE MAKE A COPY FOR YOUR RECORDS

Applicant's Name	Social Security Number

4 MEDICAL AND GENERAL (Continued)

(3) If you had coverage from any Medicare plan other than the Medicare plan within the last 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.

START ____/____/____ END ____/____/____

(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ☐ Yes ☐ No

(b) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No

(c) Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐ Yes ☐ No

(4) Do you have another Medicare supplement policy in force? ☐ Yes ☐ No

IF YES,

(a) With what company and what plan do you have? _____

_____

(b) Do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No

(5) Have you had coverage under any other health insurance plan within the past 63 days? (for example, an employer, union or individual plan) ☐ Yes ☐ No

IF YES,

(a) With what company and what kind of policy? _____

_____

(b) What are your dates of coverage under the policy? (if you are still covered under the other policy, leave "END" blank). START ____/____/____ END ____/____/____

5 GUARANTEED ISSUE OR OPEN ENROLLMENT

Please refer to the Guaranteed Issue Guidelines furnished with the Outline of Coverage. If you are applying during open enrollment or if you are eligible for guaranteed issue, please indicate which open enrollment or guaranteed issue provision applies to you with respect to this Medicare supplement application: _____.

Please attach a copy of your termination notice, HIPAA certificate or other correspondence to validate your eligibility for open enrollment or guaranteed issue.

PLEASE MAKE A COPY FOR YOUR RECORDS

Applicant's Name	Social Security Number

6 STATEMENT OF HEALTH QUESTIONS (Please answer the following questions to the best of your knowledge.)
Please note: If you are applying during open enrollment or you are eligible for guaranteed issue, you are not required to answer the following health questions.

6a	Are you currently hospitalized, bedridden, confined to a nursing facility, require the use of a wheelchair, receiving home health care in the past 90 days; or has any such care been medically advised by a licensed medical practitioner?	☐ Yes ☐ No ☐ Not Sure
6b	**In the past two (2) years,** have you been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Yes ☐ No ☐ Not Sure
6c	**In the past two (2) years,** have you consulted a physician, licensed medical provider, been diagnosed, treated or advised to have treatment for Alzheimer's Disease, Senile Dementia, Organic Brain Disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS), Parkinson's Disease, Muscular Dystrophy or paralysis?	☐ Yes ☐ No ☐ Not Sure
6d	**In the past two (2) years,** have you consulted a physician, licensed medical provider, been diagnosed, treated or advised to have treatment for Diabetes requiring the use of Insulin, kidney failure, kidney dialysis, received an organ transplant or awaiting an organ transplant?	☐ Yes ☐ No ☐ Not Sure
6e	**In the past two (2) years,** have you consulted a physician, licensed medical provider, been diagnosed, treated or advised to have treatment for:	
	1) Congestive Heart Failure, Heart Attack, Angina (chest pain), Coronary Artery Disease, Cardiomyopathy, Stroke (CVA), Transient Ischemic Attack (TIA), Heart Rhythm Disorders requiring pacemaker or defibrillator?	☐ Yes ☐ No ☐ Not Sure
	2) Heart or circulatory surgery of any type including Angioplasty, Bypass, Stent Placement or a Valve Replacement?	☐ Yes ☐ No ☐ Not Sure
	3) Cancer (except skin cancer), Melanoma, Hodgkin's Disease, Leukemia or Multiple Myeloma?	☐ Yes ☐ No ☐ Not Sure
	4) Mental or Nervous Disorder requiring Psychiatric care, Alcohol or Drug Abuse (prescription or non-prescription), Cirrhosis of the Liver or Hepatitis C?	☐ Yes ☐ No ☐ Not Sure
	5) Disabling/Crippling Arthritis, Osteoporosis with compression fractures, Degenerative Bone Disease, Systemic Lupus, or any other Connective Tissue Disease?	☐ Yes ☐ No ☐ Not Sure
	6) Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other Lung Disease, or require the use of oxygen therapy to assist in breathing?	☐ Yes ☐ No ☐ Not Sure
6f	Have you been hospitalized two or more times within the past 24 months (2 years)?	☐ Yes ☐ No ☐ Not Sure
6g	Have you been advised by a licensed medical provider to have surgery, medical tests or treatment that has not been performed or have had medical test(s) for which you have not received the results?	☐ Yes ☐ No ☐ Not Sure
6h	Have you taken any prescription medications within the past 12 months (1 year)? If **YES**, provide details below (attach a separate sheet if necessary):	☐ Yes ☐ No ☐ Not Sure

Medication	**Dosage**	**Medication**	**Dosage**

6i	Have you smoked or used any tobacco product within the past two (2) years?	☐ Yes ☐ No ☐ Not Sure
6j	**List current height** _____ **weight** _____	

PLEASE MAKE A COPY FOR YOUR RECORDS

Applicant's Name	Social Security Number

7 PLAN SELECTION AND PREMIUM PERIOD OPTIONS

a. Select the Medicare Supplement Plan you are applying for: (choose one)

☐ Plan A ☐ Plan B ☐ Plan F ☐ Plan G ☐ Plan N

b. Select your Premium Period: (choose one) - This is the frequency at which you want to pay your premiums.

☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

c. Monthly Premium Rate $ _____***** (The monthly premium rate can be found in the Outline of Coverage.)

***If your current enrollment status required you to complete the Statement of Health Questions in Section 6 and you are a smoker, you will need to adjust your Monthly Premium Rate as follows:**

If you answered "Yes" to Question 6i on page 4, multiply this amount by 1.10 to determine your monthly premium rate. For example, if your monthly premium rate shown in the Outline of Coverage is $100, multiply $100 by 1.10, which equals $110. This is your new monthly premium rate and this is the amount you need to show on line 7c.

8 PREMIUM PAYMENT OPTIONS - Total Amount you are Submitting for the Premium Period Selected in 7b.

IMPORTANT NOTE: Your monthly premium rate will differ depending on the Plan you choose and how you choose to pay. If you choose to have us bill you each month (Direct Billing), your monthly premium rate will be the amount shown in the premium rate table included in the Outline of Coverage. If you choose to pay using Electronic Funds Transfer (EFT) and you are applying for either Plan G or N, you will receive a $2 discount off the monthly premium rate shown in the Outline of Coverage. You will see where to choose your payment option and how to calculate the amount below.

☐ **MONTHLY PREMIUM RATE* -** Amount from 7c above, minus the discount for choosing the EFT option, if applicable.

a) Monthly Premium Rate $ _____ (EFT amount - discount applies only if you are applying for either Plan G or Plan N)

b) Monthly Premium Rate $ _____ (Direct Billing amount)

☐ **QUARTERLY PREMIUM RATE** - (monthly rate from line 8a multiplied by 3) $ _____

☐ **SEMI-ANNUAL PREMIUM RATE** - (monthly rate from line 8a multiplied by 6) $ _____

☐ **ANNUAL PREMIUM RATE** - (monthly rate from line 8a multiplied by 12) $ _____

***If you are paying with a personal check, you must include at least the first month's premium with your application.**

Please make checks payable to **Aetna Life Insurance Company.**

9 REQUESTED EFFECTIVE DATE: 1st of _____ (month)

PLEASE MAKE A COPY FOR YOUR RECORDS

Applicant's Name	Social Security Number

10 **PAYMENT OPTIONS –** Please select the method of payment for your premium payments.

- ☐ Electronic Funds Transfer (EFT) - complete the EFT information below.
- ☐ Bill me (Direct Billing)

Electronic Funds Transfer (EFT) Option

Checking Account Number: _____

Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Bank: _____

Name(s) on Checking Account: _____

Authorized Signature: X _____

Terms of Agreement: My account at the institution named above 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.** I understand that by checking the Electronic Funds Transfer (EFT) box above and with my application signature on **Page 7, Section 11**, I am accepting the terms of the Electronic Funds Transfer Agreement. Aetna Individual Medicare Supplement Plan policyholders must continue to pay their Medicare Part B premium and Part A if applicable.

NOTE:Aetna reserves the right to refuse/terminate electronic payment services at any time. This agreement remains in effect until Aetna/member terminates it. Aetna may require 48 hours to process the policyholder's notice of termination.

PLEASE MAKE A COPY FOR YOUR RECORDS

Applicant's Name	Social Security Number

11 RELEASE AUTHORIZATION – PLEASE READ CAREFULLY BEFORE SIGNING

Please sign and date where indicated on this page. **PLEASE MAKE A COPY FOR YOUR RECORDS**

IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN. By filing this Application and applying for this coverage, I agree to or with the following:

1. Aetna may decline this Application. No coverage comes into effect until Aetna approves this Application.
2. Coverage and benefits, once they come into effect, are contingent on a timely and accurate payment of premiums and any other contribution provided in the plan documents. If premium payments are not paid on time and accurately, your coverage will be terminated. If you are terminated for nonpayment of premium, you may no longer be eligible to enroll in Aetna's Individual Medicare Supplement Plan.
   Important Note: The Monthly Premium Rate(s) selected/calculated by the Applicant in Sections 7(c) and 8 will be validated for accuracy by Aetna prior to approval of this Application. If Aetna determines that an incorrect Monthly Premium Rate has been selected/calculated, the Applicant will be contacted by Aetna, the appropriate Monthly Premium Rate will be assessed and the Applicant will be required to acknowledge acceptance of the corrected Monthly Premium Rate prior to approval of this Application.
3. I authorize Aetna to request my medical records, any prescribed medication history and any other medical or pharmaceutical information to process my Application and to make a decision on the approval or disapproval of my Application. I authorize any physician, other healthcare professionals, hospital, clinics, labs, pharmacies, pharmacy benefit managers or any other healthcare organization ("Providers") that provided treatment or any other service to me to disclose the information required by Aetna and described above to Aetna and/or its designated agents. I understand that I may revoke this authorization at any time while Aetna is determining eligibility for the coverage requested. To do so, I must notify Aetna in writing prior to the issuance of the policy. Revocation of this authorization will result in the closure of my Application.
4. I understand that Aetna will rely on such information to: 1) underwrite this Application for coverage, make eligibility, risk rating, policy issuance and enrollment determination; 2) administer claims and determine or fulfill responsibility for coverage and provisions of benefits; 3) administer coverage; and 4) conduct other insurance operations according to federal and state laws and regulations. I authorize Aetna to use such information and to disclose such information to affiliates, Providers, payers, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that Aetna will comply with the HIPAA Privacy Rules and that disclosure of such information will be done in accordance with applicable law.
5. I understand that I am entitled to receive a copy of this Application upon request, and that a photocopy is as valid as the original.
6. Providers are independent contractors and are not agents of Aetna.
7. Information on insurance agent/broker compensation is available from your agent.
8. I have an obligation of communicating to Aetna in writing any medical conditions which occur to Applicant listed in this Application after the Application date and before the effective date of the coverage, if approved.
9. **Attention California Residents:** For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
   NOTICE: CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

I UNDERSTAND THAT IF MY SIGNATURE/DATE DO NOT APPEAR AND/OR ARE NOT CURRENT AND/OR MY ANSWERS ARE INCOMPLETE, my application will be declined.

I acknowledge receipt of a copy of "A Guide to Health Insurance for People with Medicare" and an Outline of Coverage, and that I have made a copy of this Application.

Applicant's Signature:  _____ Application Date: _____

Power of Attorney or Legal Guardian Signature*: _____

* If Applicant is unable to sign, a court-appointed legal guardian or a designee authorized by state law must sign above. Attach a copy of the document that designates this person as the Applicant's representative.

PLEASE MAKE A COPY FOR YOUR RECORDS

Applicant's Name	Social Security Number

12 INSURANCE PRODUCER CERTIFICATION – This Section To Be Completed By Insurance Producer/Aetna Sales Representative Only

The undersigned Insurance Producer certifies that the Applicant has read, or had read to him/her, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

Did you see the proposed applicant at the time this application was executed? ☐ Yes ☐ No

If "No," please explain: _____

List all health insurance policies (including Medicare Supplement policies) you have sold to the applicant which are still in force. (attach separate sheet, if necessary)

Company: _____ Type: _____

Company: _____ Type: _____

List all health insurance policies sold to the applicant within the past 5 years which are no longer in force.

Company: _____ Type: _____

Company: _____ Type: _____

I certify: (1) I have accurately recorded the information supplied by the Applicant; and (2) I have given an Outline of Coverage for the policy applied for and I reviewed the current health insurance coverage of the Applicant and find additional coverage of the type and amount applied for the Applicant's needs is:

☐ Appropriate ☐ Inappropriate

Signature of Insurance Producer *(Required, if applicable)*		**Signature of General Agent/FMO** *(Required, if applicable)*	
Date	E-mail Address	Date	E-mail Address
Name of Insurance Producer (print name) Health And Life Insurance Services		Name of General Agent/FMO (print name)	
SS# of Insurance Producer 954657410		General Agent/FMO TIN Number	
TIN of Agency for Commissions if other than Insurance Producer		Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)	
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)			
Telephone Number (800) 243-8100	Fax Number (800) 501-9222	Telephone Number ( )	Fax Number ( )

13 AETNA SALES REPRESENTATIVE

Last Name of Aetna Sales Representative (print name)	First Name of Aetna Sales Representative (print name)
Address of Aetna Sales Representative	Aetna Number
	Telephone Number of Aetna Sales Representative

Send Policy to: ☐ Producer ☒ Insured

PLEASE MAKE A COPY FOR YOUR RECORDS

Applicant's Name	Social Security Number

14 NOTICE OF LANGUAGE ASSISTANCE

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-877-287-0117. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-877-287-0117. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-877-287-0117 與我們聯絡。欲取得其他協助，請致電1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-877-287-0117 . Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-877-287-0117번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-877-287-0117. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-877-287-0117 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-877-287-0117. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-877-287-0117までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-877-287-0117 تماس بگیرید. برای دریافت کمک بیشتر، به (اداره بیمه کالیفرنیا) CA Dept. of Insurance به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-877-287-0117 'ਤ ਸਾਨ ਫ਼ਨ ਕਰੋ। ਵਧੇਰ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-877-287-0117 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-877-287-0117 . للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 Arabic.

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-877-287-0117. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

CDI Notice of Language Assistance-Trad

PLEASE MAKE A COPY FOR YOUR RECORDS

Aetna Medicare

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

Aetna Life Insurance Company
PO Box 13547, Pensacola, FL 32591-3547
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

If you intend to cancel or terminate existing Medicare supplement or Medicare Advantage insurance and replace it with coverage issued by Aetna Life Insurance Company, please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

STATEMENT TO APPLICANT BY ISSUER, AGENT, BROKER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
- ☐ Other. (Please specify) _____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement Medicare Supplement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with the new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for Aetna Life Insurance Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

Signature of Agent, Broker or Other Representative	Date
Typed Name and Address of Issuer or Agent	
Applicant's Signature	Date

PLEASE MAKE A COPY FOR YOUR RECORDS

Aetna Medicare

Aetna Individual Medicare Supplement Plan Application
Aetna Life Insurance Company

INSTRUCTIONS:

To be considered complete, all sections on this form must be filled out, unless marked optional. Please sign and date the form and make a copy for your records. **Incomplete forms could delay processing your enrollment.** For information call **1-800-557-5078**; TTY/TDD (Hearing Impaired) **1-888-200-6124**.

PLEASE READ THE FOLLOWING CONSUMER PROTECTION INFORMATION:

You do not need more than one Medicare Supplement policy.

- If you purchase this policy, you may want to evaluate your existing health coverage and decide whether you need multiple coverages.
- You may be eligible for benefits under Medi-Cal and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this extension within 90 days of becoming eligible for Medi-Cal.
- If you are no longer entitled to Medi-Cal, 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 Medi-Cal 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 suspension.
- 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.
- Counseling services may be available in this state to provide advice concerning your purchase of Medicare Supplement insurance and medical assistance through the state Medi-Cal program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.
- A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet Web site (www.insurance.ca.gov).