Aetna AFA Medical and Stop Loss Application

Instructions: You must complete this enrollment form in full. If you do not, we will return it to you, and that can delay its processing. You alone are responsible for its accuracy and completeness. **If waiving coverage, please complete sections A and B.**

Employer name	Effective date
COBRA for: ☐ Employee ☐ Dependent **Length of continuation:** ☐ 18 ☐ 36 ☐ Other _____ **Original qualifying event date** _____ **Qualifying event** _____	

A. Employee information

Last name, first name, middle initial	City, state	ZIP code	Date of hire
Number of hours worked a week _____	**Check one:** ☐ Full time ☐ 1099 ☐ Seasonal ☐ COBRA ☐ Part time ☐ Retired ☐ Temporary ☐ Union		

Employee acknowledgement: I understand that it is fraud to file an application for coverage, an enrollment form or claim that contains materially false information knowingly and with intent to defraud. It is illegal to conceal, for the purpose of misleading, information concerning any material fact. A person who commits fraud or intentionally misrepresents material facts is subject to civil penalties and may be charged with a crime. If you commit fraud or intentionally misrepresent material facts, your coverage can be cancelled or your rates can be increased back to your effective date.

I certify that all information and statements on this enrollment form are true and complete to the best of my knowledge. I have authority to make statements on behalf of any dependents listed on this form. *If I become aware of any new information after I have completed this enrollment form but before the effective date that would change any answer on this form or make me report something not reported on this form, I agree to provide that information to Aetna as soon as possible.*

Conditions of enrollment: I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until Aetna approves both this enrollment form and the employer application. I agree that my employer or its agent may send this enrollment form to Aetna. I authorize all my doctors, pharmacies, hospitals and other health care providers ("providers") to give Aetna any and all personal health information about me and others listed on this form. This authorization covers all health matters including those involving mental health, substance abuse and HIV / AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, 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. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.

Please sign here ONLY if you are enrolling in coverage for yourself and / or dependents.

X Employee signature _____ **Date** *(Month/Day/Year)* _____

B. Decline / waive – *To be completed if medical coverage is declined or refused by an eligible employee and / or their eligible family members.*

I acknowledge I have been given the right to apply for this coverage; however, I am electing not to enroll. By declining this group coverage I acknowledge that I and / or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. I and / or my dependents have made this decision of my / their own accord with no pressure from my employer, my employer's agent or the insurance carrier.

Medical coverage declined for:	***Please sign here ONLY if you are declining coverage for yourself and / or dependents.***
☐ Myself ☐ Spouse / civil union / domestic partner ☐ Children	**X Employee signature** _____ **Date** *(Month/Day/Year)* _____

C. Individuals enrolling – List individuals enrolling or adding, changing or removing coverage. If more space is needed check here ☐ and use a separate sheet of paper.

(A)dd **(C)**hange **(R)**emove	**Last name, first name, middle initial**	**Sex** (M/F)	**Birthdate** (MM/DD/YYYY)	**Height**	**Weight**	**Tobacco or nicotine use** (including E-cigarette devices)
	☐ Employee 1.					☐ Yes ☐ No
	☐ Spouse ☐ Civil union ☐ Domestic partner 2.					☐ Yes ☐ No
	☐ Child ☐ Stepchild ☐ Other 3.					☐ Yes ☐ No
	☐ Child ☐ Stepchild ☐ Other 4.					☐ Yes ☐ No
	☐ Child ☐ Stepchild ☐ Other 5.					☐ Yes ☐ No

D. Health Questionnaire – Complete for all individuals enrolling for coverage.

Have you or anyone applying for coverage consulted with or been examined, diagnosed, or treated by any health care professionals during the last five (5) years for any illness, injury or health condition in any of the categories listed below? If "yes," please check the box that most appropriately describes the condition(s) and explain fully below (page 4).

1. Cancer / tumor / cyst ☐ **Yes** ☐ **No**

☐ Brain ☐ Breast ☐ Esophagus ☐ Stomach ☐ Colon ☐ Leukemia ☐ Lymphoma ☐ Multiple myeloma ☐ Kidney ☐ Liver ☐ Lung ☐ Melanoma ☐ Pancreas ☐ Prostate
☐ Testicular ☐ Cervical ☐ Ovarian ☐ Uterine ☐ Throat ☐ Thyroid ☐ Other cancer (type / location _____) ☐ Non-malignant tumor (type / location _____)
Diagnosis date _____ **Cancer stage (0-4)** _____ **(if known) Cancer category (In situ, localized, regional, distant)** _____ **(if known)**
Treatment: ☐ **Surgery date** _____ ☐ **Chemo timeframe** _____ ☐ **Radiation timeframe** _____
☐ **Remission** ☐ Yes ☐ No **If yes, provide date of remission** _____

2. Heart / vascular ☐ **Yes** ☐ **No**

☐ Aneurysm (location _____) ☐ Blocked arteries (e.g., carotid, heart, abdomen, legs) ☐ Heart attack ☐ Heart valve disorder ☐ Congestive heart failure ☐ Cardiomyopathy
☐ Irregular or abnormal heart rhythm ☐ Stroke ☐ Vasculitis (type _____) ☐ Bypass / angioplasty / stent (location _____) ☐ Pacemaker or cardiac defibrillator
☐ Other (specify details below)

3. Blood / clotting disorder ☐ **Yes** ☐ **No**

☐ Hemophilia (specify type below) ☐ Anemia (specify type below; e.g., sickle cell, hemolytic, aplastic) ☐ Blood clots ☐ Other (specify details below)

4. Reproductive / Gynecological ☐ **Yes** ☐ **No**

☐ Current pregnancy: specify if it's a spouse, dependent child or other expectant parent even if not listed on the application (due date _____ , if multiples # ____, any complications _____)
☐ Intending to adopt ☐ Infertility ☐ Other Gynecological conditions (specify details below)

5. Gastrointestinal / endocrine ☐ **Yes** ☐ **No**

☐ Diabetes ☐ Crohn's / ulcerative colitis ☐ Autoimmune hepatitis ☐ Hepatitis B (specify below if acute or chronic) ☐ Hepatitis C (if cured, when did treatment end? _____) ☐ Cirrhosis
☐ Pancreatitis ☐ Growth disorder ☐ Adrenal, pituitary, thyroid gland disorder (specify type below) ☐ Other disorders of the gallbladder, stomach, pancreas, liver, colon (specify type below)

6. Brain / neurological ☐ **Yes** ☐ **No**

☐ Amyotrophic lateral sclerosis ☐ Cerebral palsy ☐ Neuropathy / polyneuropathy ☐ Multiple sclerosis ☐ Myasthenia gravis ☐ Muscular dystrophy ☐ Brain and / or spinal cord disorder or injury
☐ Paralysis, quadriplegia, paraplegia ☐ Other (specify details below)

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D. Health Questionnaire *(continued)*

7. Immune / dermatology ☐ **Yes** ☐ **No**

☐ HIV or AIDS ☐ Immunodeficiency disorder ☐ Connective tissue disorder (specify type below; e.g., lupus, scleroderma) ☐ Hereditary angioedema
☐ Skin disorder (specify type below; e.g., psoriasis, eczema, ulcers, infections) ☐ Other (specify details below)

8. Lung / respiratory ☐ **Yes** ☐ **No**

☐ Cystic fibrosis ☐ COPD, chronic bronchitis, emphysema ☐ Pulmonary hypertension ☐ Pulmonary fibrosis ☐ Other (specify type below; e.g., asthma, sarcoidosis, etc.)

9. Urinary / kidney ☐ **Yes** ☐ **No**

☐ Kidney disease / disorder (specify type below) ☐ Kidney failure ☐ Dialysis: date started _____ ☐ Dialysis possible within the next 18 months ☐ Bladder disorder
☐ Prostate disorder ☐ Other (specify details below)

10. Musculoskeletal ☐ **Yes** ☐ **No**

☐ Rheumatoid or psoriatic arthritis (specify type below) ☐ Disorder of the back / neck / spine ☐ Disorder of the joints (specify location; e.g., hips, knees, shoulders) ☐ Chronic pain disorder
☐ Osteomyelitis ☐ Amputation ☐ Other (specify details below)

11. Mental health / substance abuse ☐ **Yes** ☐ **No**

☐ Alcohol and / or drug abuse (specify type below) ☐ Eating disorder ☐ Anxiety / depression ☐ Bipolar disorder ☐ Schizophrenia ☐ Suicide attempt ☐ Oppositional defiant / conduct disorder
☐ Autism ☐ ABA therapy ☐ Other (specify details below)

12. Transplant ☐ **Yes** ☐ **No**

☐ Organ or bone marrow / stem cell transplant already performed (date _____) ☐ Future transplant planned / scheduled (date _____)
☐ Transplant discussed / recommended / possible within the next 18 months ☐ Transplant complications ☐ Other (specify details below)

13. Birth / inherited conditions ☐ **Yes** ☐ **No**

☐ Premature birth (gestational age: ____ # weeks) ☐ Congenital birth defect ☐ Genetic / metabolic disorder ☐ Any syndrome (specify details below) ☐ Other (specify details below)

14. Eyes / ears / nose / throat ☐ **Yes** ☐ **No**

☐ Acoustic neuroma ☐ Cataracts ☐ Cleft lip / palate ☐ Deviated septum ☐ Glaucoma ☐ Retinopathy ☐ Chronic ear infections ☐ Chronic sinusitis ☐ Other (specify details below)

15. Medications ☐ **Yes** ☐ **No**

Current medications:
Person _____ # of meds ____ Person _____ # of meds ____ (list medication name(s) and diagnosis below)
Medications taken within the past 12 months:
Person _____ # of meds ____ Person _____ # of meds ____ (list medication name(s) and diagnosis below)

16. Incapacitated ☐ **Yes** ☐ **No**

Reason: ☐ Disabled ☐ Handicapped ☐ Congenital disorder ☐ Other (specify details below)

17. Other ☐ **Yes** ☐ **No** (specify details below)

☐ Hospitalizations in the past 5 years ☐ Future surgeries or hospitalizations discussed / planned / recommended / scheduled or possible within the next 18 months
☐ Other conditions not addressed elsewhere in the application

Continued on next page

D. Health Questionnaire *(continued)*

Provide details below for all "yes" answers indicated above. If additional space is needed, attach a separate sheet. All attachments must be signed and dated by the applicant.							
Ques. No.	**Enrollee name**	**Conditions / diagnosis**	**Date diagnosed**	**Treatment** (include surgery, hospitalized, durable medical equipment / supplies, etc.)	**Medication names** (include those taken orally, injected, infused, topically, nasally, inhaled, etc.)	**Dates treated**	**Is treatment ongoing?** If **yes**, provide details of any current OR future treatment.