Virginia Medical Plans

Application Instructions for Aetna

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter and application and fax or mail to Virginia Medical Plans for signature. If you do not have access to a fax machine, send the completed application to Virginia Medical Plans along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Select your preferred billing method.
- Sign and date the application.
- Estimated first month's premium must accompany the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Aetna Insurance** if you are not paying by credit card for the first month.

Mail completed applications and check to:

Virginia Medical Plans
Attn: New Enrollment
1404 Northpoint Glen Ct.
Herndon, VA 20170

Virginia Medical Plans will review your application for completeness and accuracy before submiting it to Aetna for processing. This may reduce the underwriting time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 800-867-0800 or 888-396-2341 or e-mail us at jkatz@vamedicalplans.com.

Norvax form #IN-1

Virginia Medical Plans

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**Please FAX this cover letter with the completed application to:
Virginia Medical Plans
FAX# 888-514-4258

Dear Virginia Medical Plans,
Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

☐ Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.

☐ I will contact Virginia Medical Plans at 800-867-0800 or 888-396-2341 to verify receipt of my application.

I will send the original application as soon as I have been contacted by Virginia Medical Plans with confirmation that my application has been received by fax and reviewed for completeness.

Norvax form #CS-1

aetna®

Virginia
Application for Aetna Individual Health Insurance

Aetna Life Insurance Company

Corporate Address: Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Primary Applicant's Name

Applicant's Social Security Number

INSTRUCTIONS:

- **Please complete in blue or black ink only. PRINT clearly.**
- **The information you provide is confidential.**
- **All answers must be complete and truthful.**
- **Intentional misrepresentation may result in the policy being terminated.**

Section A – Primary Applicant Information (for parent/guardian for Child-Only application)

Primary Applicant Last Name	First Name	Middle Initial
Home Address (No PO Boxes)		Apt. Number
City	State	ZIP Code
Relationship (If Child-Only Application)		
Mailing Address (If different from your Home address)		
City	State	ZIP Code
County	E-mail Address	
Telephone Number **Primary** (_____)_____ **Secondary** (_____)_____	If we need to call you with any question about your application, when is the best time to reach you? ☐ Morning ☐ Afternoon ☐ Evening	

Section B – Coverage Information

Application Type (Select one):

Annual Open Enrollment Period

☐ New medical coverage ☐ Child-Only Application (Children up to age 21)

☐ Change current coverage ☐ Add dependent(s) to current coverage

Your Effective Date will be assigned by Aetna, based on your signature date.

Primary Applicant's Name

Section C – Special Enrollment Period

If you are applying outside of the Annual Open Enrollment Period and one of the events listed below applies to you, check the appropriate box. The Special Open Enrollment Period begins on the date of the event checked and continues for 60 days.

Date of Event	Event
_____	☐ Loss of employer coverage due to termination of employment, reduction in hours, or coverage no longer offered to my employment class, loss of COBRA coverage.
_____	☐ Loss of employer or individual coverage because no longer eligible as a dependent.
_____	☐ Loss of employer or individual coverage because of divorce from policyholder, or policyholder enrolled in Medicare.
_____	☐ Loss of Medicaid or CHIP coverage.
_____	☐ Coverage needed for new dependent through marriage.
_____	☐ Coverage needed for new dependent through birth, adoption or placement for adoption.
_____	☐ Coverage needed following loss of eligibility for Exchange subsidies.
_____	☐ A permanent move.
_____	☐ Other, please explain. _____

Section D – Coverage Selection

Choose the plan that best meets your needs.

*****Catastrophic:**

- ☐ **Aetna Catastrophic 100% PD**
- ☐ **Aetna Whole Health Catastrophic 100% PD**
- ☐ **Aetna Coastal VA HP Catastrophic 100% PD**

***Must be under age 30 or qualify for an exemption. Proof of exemption will be required for each individual applying.

Bronze:

- ☐ **Aetna Bronze Deductible Only HSA PD**
- ☐ **Aetna Bronze $25 Copay PD**
- ☐ **Aetna Whole Health Bronze Deductible Only HSA PD**
- ☐ **Aetna Whole Health Bronze $25 Copay PD**
- ☐ **Aetna Coastal VA HP Bronze Deductible Only HSA PD**
- ☐ **Aetna Coastal VA HP Bronze $25 Copay PD**

Silver:

- ☐ **Aetna Silver $5 Copay 2750 PD**
- ☐ **Aetna Silver $10 Copay PD**
- ☐ **Aetna Whole Health Silver $5 Copay 2750 PD**
- ☐ **Aetna Whole Health Silver $10 Copay PD**
- ☐ **Aetna Coastal VA HP Silver $5 Copay 2750 PD**
- ☐ **Aetna Coastal VA HP Silver $10 Copay PD**

Gold:

- ☐ **Aetna Gold $5 Copay PD**
- ☐ **Aetna Whole Health Gold $5 Copay PD**
- ☐ **Aetna Coastal VA HP Gold $5 Copay PD**

Primary Applicant's Name

Section E – Persons Requesting Coverage

List all family members you wish to be covered under this policy.

Dependent children are eligible up to age 26.

For a Child-Only application, start listing children at Child 1

☐ Check here if more space is needed to provide information for additional dependents. Use a separate sheet of paper and staple to the back of this application.

If any person has regularly used tobacco products (cigarettes, pipe, cigars, snuff, or chewing tobacco) within the last 6 months, check Yes as Tobacco User below. Regular use means an average of four or more times per week.

Primary Applicant Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Spouse Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Domestic Partner Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 1 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 2 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No
Child 3 Name (Last, First, Middle Initial)			Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender ☐ M ☐ F	Tobacco User ☐ Yes ☐ No

To be completed by the primary Applicant

Marital Status ☐ Married ☐ Domestic Partner ☐ Single	Are you a resident of the state in which you are applying? ☐ Yes ☐ No
If you are currently covered by accident and sickness insurance, is this plan intended to replace your current coverage? ☐ Yes ☐ No	
How would you like Aetna Life Insurance Company to communicate with you regarding your application and coverage? ☐ E-mail ☐ Mail	Would you like to receive emails from us regarding your benefits, programs and general health information? ☐ Yes ☐ No
Would you like to turn off paper? ☐ Yes ☐ No If you turn off paper, we will send you emails about your claims and other activity on your account. You can also view your statements and communications online. If you want to change this election, you can contact Member Services at the number on the back of your ID Card.	
Are any applicants enrolled in or entitled to Medicare benefits? ☐ Yes ☐ No If Yes, provide name(s) of these applicants: _____	

continued

Primary Applicant's Name

Section E – Persons Requesting Coverage (Continued)

To be completed by the primary Applicant

Are all applicants listed on this application Citizens of the United States? ☐ Yes ☐ No

If No, provide Name, most recent date of arrival in the U.S.

Name	Most recent arrival date

Do you read and write English? ☐ Yes ☐ No (If No, the Statement of Accountability must be completed.)

If No, Primary Spoken Language: _____ Primary Written Language: _____

Did you complete this application? ☐ Yes ☐ No (If No, the Statement of Accountability must be completed.)

Statement of Accountability – Must be completed if the applicant answered "No" to read or write English or the applicant did not complete this application.

I _____, acting as (describe your relationship) _____
have personally read this form to the applicant and completed the application because:

☐ Applicant does not have sufficient command of the English language to complete this application

☐ Applicant is legally incapacitated and unable to complete this application

I have read and explained in detail the contents of this application.

_____

If translated, I also fully explained to the applicant the "Authorization to Disclose Personal Health Information" and "Signature(s) Required" under **Sections F and H**.

Signature of Representative ***(Required)***	Today's Date ***(Required)***

Print Name

Street Address

City	State	ZIP Code	Telephone Number ( )

Primary Applicant's Name

Section F – Authorization to Use and Disclose Protected Health Information

Please read the following carefully before completing your authorization. You may refuse to sign this authorization.

Purposes of this Authorization

By signing this authorization, I authorize Aetna Life Insurance Company (Aetna) or Aetna's representatives, to request, receive and use prescribed medication history or other pharmaceutical information, hospital records, physician records, claims or benefit records or lab results (all of which are "Protected Health Information" or "PHI") as necessary a) to verify tobacco use and b) to coordinate medical care and case management. I authorize Aetna to disclose my PHI for the purposes stated above to other persons or organizations performing services on Aetna's behalf.

I further authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, lab, pharmacy, pharmacy benefit manager or other medical or medically related facility, insurance or reinsuring company, or other organization, institution, or person that has any record or knowledge of my health to disclose such information to Aetna to the extent permitted by law.

I understand that Aetna may pay a fee to a third party to collect my health information. The health information released to Aetna may be related to chronic diseases, mental illness, alcohol or substance abuse, Human Immunodeficiency Virus (HIV) infection, or Acquired Immune Deficiency Syndrome (AIDS),

Aetna may not condition your treatment, payment, enrollment or eligibility for benefits, on whether or not you sign this authorization.

Health information received by Aetna will not be re-disclosed without your authorization unless permitted by law, as described in Aetna's Notice of Privacy Practices. Information that is re-disclosed may not be protected under federal privacy laws.

I or a person authorized to act on my behalf may obtain a copy of this authorization upon request.

I agree this Authorization shall be valid for eighteen (18) months from the signature date below.

I understand that I may revoke this authorization at any time by giving advance written notice to Aetna. My revocation will not have any effect on actions Aetna has already taken before receiving my notice.

Primary Applicant's or Parent/Guardian's Signature	Date
Spouse's Signature	Date
Domestic Partner's Signature	Date
Dependent's Signature (age 18 or older)	Date
Dependent's Signature (age 18 or older)	Date

Primary Applicant's Name

Section G – Payment Options (Select the method of payment for your initial application and following premium payments.)

Initial Payment

☐ Easy Pay – Electronic Check (complete the EFT information below)

☐ Credit Card (complete the credit card information below)

Recurring or Follow Up Payments

☐ Easy Pay (complete the EFT information below)

☐ Monthly Billing Statement

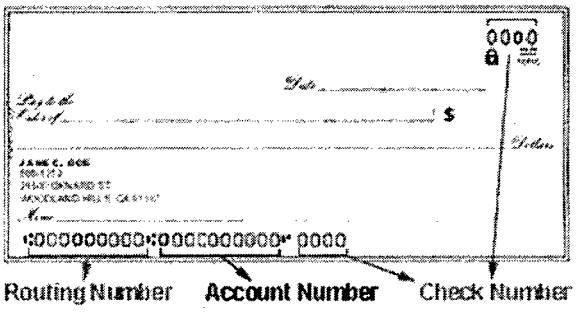
Easy Pay (Electronic Fund Transfer – EFT)

Checking Account Number: _____

Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Bank: _____

Name(s) on Checking Account: _____



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.** I understand that by electing the Easy Pay box above and with my application signature in **Section H**, I am accepting the terms of the Easy Pay Agreement.

Any rate adjustment made in accordance with the enrollment process will be automatically charged to your account upon approval of your application *prior to the effective date*. Please be advised that tobacco use may result in an increase to the standard premium.

NOTE: 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 (**Section H**) even if not applying.

Credit Card Payment Option

Credit Card Type ☐ Visa ☐ MasterCard	Cardholder's Name (exactly as it appears on the card)
Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	Card Expiration Date

Credit card payment is for your initial premium payment only and will be charged upon approval of your application *prior to the effective date*. You must elect EFT or monthly billing (check or money order) for your next premium payment.

Any rate adjustment made in accordance with the enrollment process will be automatically charged to your account. **Please be advised that tobacco use may result in an increase to the standard premium.**

Primary Applicant's Name

Section H – Signature(s) Required – All Applicants (Primary/Spouse and dependents) age 18 and older must read and sign this form below.

By signing this form you agree to the following:

1. The answers in this application are true and complete to the best of my knowledge or belief.
2. The children listed on this application are eligible for coverage as my dependents.
3. I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by Aetna.
4. I have read this entire application, or it has been read to me.
5. The information I have provided in this application will be used by Aetna to determine whether to issue coverage and the premium amount for such coverage.
6. No coverage shall be in force until Aetna processes this application and Aetna has notified me of my effective date.
7. This application will become part of the contract between Aetna and me.
8. I or my legal representative has the right to receive a copy of this application upon request. I agree that a photocopy shall be as valid as the original. A legal facsimile signature shall have the same force and effect as the original.
9. I authorize Aetna to electronically transmit the information contained in this application.
10. The undersigned Applicant(s) and agent (if applicable) certify that the Applicant(s) have read, or had read to him/them 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.

If while covered under this plan, you are also covered under an Aetna group plan, you will be entitled only to the benefits of the group plan. If you have insurance coverage with another insurer, we will only pay benefits for covered benefits that exceed the benefits payable under the other coverage. In no event will Aetna's payment, if added to the payment under the other coverage, be larger than the amount payable for the health services received by the covered person.

Primary Applicant's or Parent/Guardian's Signature	Date
Spouse's Signature	Date
Domestic Partner's Signature	Date
Dependent's Signature (age 18 or older)	Date
Dependent's Signature (age 18 or older)	Date
Agent's Signature	Date

Primary Applicant's Name

Section I – Insurance Producer or Agent (Required If Applicable)

Complete if Broker of Record is an Individual Producer (not an Agency)

Print Name of Producer **Jonathan Katz**	NPN of Agent **1585616**
Signature of Producer (required if applicable)	Telephone Number (**800**) **867-0800**
E-mail Address **jkatz@vamedicalplans.com**	Fax Number (**888**) **514-4258**
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code) **1404 Northpoint Glen Court / Herndon / VA / 20170**	

Complete if Broker of Record is an Agency

Name of Agency	TIN of Agency	
E-mail Address	Telephone Number ( )	Fax Number ( )
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)		
Print Name of Producer Representing Agency	NPN Number	
Signature of Agency Representative (required if applicable)		

General Agent

Print Name of General Agent	TIN of General Agent
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)	

Aetna Sales Representative

Last Name of Agent (Print Name)	First Name of Agent (Print Name)	License Number

Section J – Contact Information

Please return this application to the agent or submit to the address listed below.

Aetna Individual Plans
PO Box 14381
Lexington, KY 40512-4381

Fax #: 866-892-8396

Website for information: http://www.aetna.com/individuals-families.html