Please mail your completed form to:

Medicare Options

Attention: Rick Plata
23331 Via Sausalito
Moreno Valley, CA 92557

Or

Fax to: (888) 391- 0562

Enrollment questions, please call Rick Plata at (888) 235-8060.

Aetna Medicare

Aetna Individual Medicare Supplement Plan Application
Aetna Life Insurance Company
PO Box 13547, Pensacola, FL 32591-3547

1 APPLICANT INFORMATION (Proposed Insured) – 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 SECONDARY ADDRESSEE INFORMATION – A copy of any notification of possible lapse will be sent to this person.

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 Medicaid program? .... ☐ Yes ☐ No
(**NOTE TO APPLICANT:** Please answer **NO** to this question if you are participating in a "Spend-Down Program" and have not met your "Share of Cost.")
IF YES,
- (a) Will Medicaid pay your premiums for this Medicare supplement policy? .... ☐ Yes ☐ No
- (b) Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium? .... ☐ Yes ☐ No

(3) If you had coverage from any Medicare plan other than the original 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 ___/___/___

PLEASE MAKE A COPY FOR YOUR RECORDS

Name	Social Security Number

5 PLAN SELECTION (Note: Please make checks payable to **Aetna Life Insurance Company.**)

Premium Period:	Insurance Plan Applied For:	Initial Premium ______________
☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual	☐ Plan A ☐ Plan B ☐ Plan F	(This amount, which can be found in the enclosed materials, must accompany the application.) **Requested effective date**: ______________

6 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.

7 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.

1.	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
2.	**In the past two (2) years,** have you tested positive for exposure to the HIV infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?	☐ Yes ☐ No
3.	**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
4.	**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
5.	**In the past two (2) years,** have you consulted a physician, licensed medical provider, been diagnosed, treated or advised to have treatment for:	
	a. 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
	b. Heart or circulatory surgery of any type including Angioplasty, Bypass, Stent Placement or a Valve Replacement?	☐ Yes ☐ No
	c. Cancer (except skin cancer), Melanoma, Hodgkin's Disease, Leukemia or Multiple Myeloma?	☐ Yes ☐ No
	d. Mental or Nervous Disorder requiring Psychiatric care, Alcohol or Drug Abuse (prescription or non-prescription), Cirrhosis of the Liver or Hepatitis C?	☐ Yes ☐ No
	e. Disabling/Crippling Arthritis, Osteoporosis with compression fractures, Degenerative Bone Disease, Systemic Lupus, or any other Connective Tissue Disease?	☐ Yes ☐ No
	f. Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other Lung Disease, or require the use of oxygen therapy to assist in breathing?	☐ Yes ☐ No
6.	Have you been hospitalized two or more times within the past 24 months (2 years)?	☐ Yes ☐ No
7.	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
8.	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

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

9.	Have you smoked or used any tobacco product within the past two (2) years?	☐ Yes ☐ No
10.	**List current height** __________ **weight** _________	

PLEASE MAKE A COPY FOR YOUR RECORDS

Name	Social Security Number

8 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.
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 (or my authorized representative is) 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 or at Aetna.com.
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. I understand that 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 material 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.

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.

9 PRODUCER CERTIFICATION – This Section To Be Completed By Producer/Aetna Sales Representative Only

The undersigned Agent 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.

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: ______________________

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

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 Producer: ______________________ Date signed: __________

Name of Insurance Producer or Agency to be assigned as Broker of Record: ______________________

TIN of Producer or Agency to be assigned as Broker of Record: ______________________ SS# if Payee is an Individual: __________

Signature of General Agent or FMO (required if applicable) ______________________ Date signed: __________

Name of General Agent or FMO (required if applicable): ______________________

TIN of General Agent or FMO: ______________________ SS# if Payee is an Individual: __________

Address and Telephone Number: ______________________

PLEASE NOTE: When commission is to be paid only to a Producer, include only Producer-specific information. When commission is to be paid to a Broker, Agency, GA or FMO, the TIN and signature are required.

Send Policy to: ☐ Agent ☐ Insured

PLEASE MAKE A COPY FOR YOUR RECORDS

Guaranteed Issue Guidelines

If you meet the eligibility requirements set forth in the Aetna Individual Medicare Supplement Plan[SM] insurance policy and one of the following conditions applies to you, you are eligible for Guaranteed Issue ("Eligible Person") and you will not be required to complete the Statement of Health part of the Application.

Open Enrollment - You are eligible for Guaranteed Issue if you are at least age 65 and apply for an Aetna Individual Medicare Supplement Plan insurance policy prior to or during the six-month period beginning with the first day of the month in which you are enrolled for benefits under Medicare Part B. You must submit evidence that you have Medicare Parts A and B with your Application.

Other Situations - You are eligible for Guaranteed Issue for an Aetna Individual Medicare Supplement Plan insurance policy if you apply for the policy in the guarantee issue time periods described below, you submit evidence of the date of termination or disenrollment with the Application, and you meet one of the following conditions:

1. You are enrolled in an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates or ceases to provide such supplemental health benefits to you; or you are enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to you because you leave the plan.
2. You are enrolled with a Medicare Advantage organization under a Medicare Advantage Plan (the "Plan") under Medicare Part C or under a Program of All-Inclusive Care for the Elderly (PACE) and any of the following apply:
   - The certification of the organization or plan under this part has been terminated; or
   - The organization has terminated or otherwise discontinued providing the Plan in the area in which you reside; or
   - You are no longer eligible to elect the Plan because:

     (i) of a change in your place of residence or other change in circumstances specified by the Secretary of the Department of Health and Human Services (the "Secretary"), excluding those circumstances where you were disenrolled from the Plan for any of the reasons described in Section 1851 (g)(3)(B) of the federal Social Security Act (e.g., where you have not paid premiums on a timely basis, or you have engaged in disruptive behavior as specified in standards under Section 1856); or

     (ii) the Plan is terminated for all enrollees residing within a particular residential service area; or
   - You demonstrate, in accordance with guidelines established by the Secretary, that:

     (i) The organization offering the Plan substantially violated a material provision of the organization's contract with the Centers for Medicare and Medicaid Services in relation to you, including the failure to provide you, on a timely basis, with medically necessary care for which benefits are available under the Plan, or the failure to provide such covered care in accordance with applicable quality standards; or

     (ii) The organization or agent or other entity acting on the organization's behalf, materially misrepresented the Plan's provisions in marketing the Plan to you; or
   - You meet such other exceptional conditions as the Secretary may provide.

3. You are enrolled with:
   - An eligible organization under a contract under Section 1876 (Medicare cost); a similar organization operating under demonstration project authority, effective for periods before April 1, 1999; an organization under agreement under section 1833(a)(1)(A) (health care prepayment plan); or an organization under a Medicare SELECT policy; and
   - Your enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 2 above.
4. You are enrolled in a Medicare supplement policy and the enrollment ceases because:
   - Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or
   - Of other involuntary termination of coverage or enrollment under the policy; or
   - The issuer of the policy substantially violated a material provision of the policy; or
   - The issuer or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to you.
5. You were enrolled under a Medicare supplement policy and you terminate enrollment and subsequently enroll, for the first time, with; (1) any Medicare Advantage organization under a Medicare Advantage Plan under Medicare Part C; (2) any eligible organization under a contract under Section 1876 (Medicare cost); (3) any similar organization operating under demonstration project authority; (4) any PACE program under Section 1894 of the Social Security Act; (5) any organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or (6) a Medicare SELECT policy, and enrollment under this section is terminated by you during any period within the first 12 months of such subsequent enrollment (during which you are permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act).
6. You, upon first becoming enrolled for benefits under Medicare Part A at age sixty-five or older, enroll in a Medicare Advantage Plan under Medicare Part C, or in a PACE program under Section 1894 of the Social Security Act, and disenroll from the plan by not later than 12 months after the effective date of enrollment.

Guaranteed Issue Time Periods:

- In the case of an individual described in situation #1, the guaranteed issue period begins on the later of: (i) the date you receive a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days after the date of the applicable notice;
- In the case of an individual described in situations #2, #3, #5 or #6 whose enrollment terminated involuntarily, the guaranteed issue period begins on the date that you receive a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;
- In the case of an individual described in situation #4 (insolvency of the issuer or bankruptcy of the non-issuer organization), the guaranteed issue period begins on the earlier of: (i) the date that you receive a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated;
- In the case of an individual described in situations #2, #4 (issuer or the policy substantially violated a material provision of the policy), #4 (the issuer or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to you), #5 or #6, who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date; and

- In the case of an individual described in this Guaranteed Issue Guide but not described in the preceding situations, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

Extended Medigap Access for Interrupted Trial Periods:

- In the case of an individual described in situation #5 whose enrollment with an organization or provider described in item (1) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment;
- In the case of an individual described in situation #6, whose enrollment with a plan or in a program described in situation #6 is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment; and
- For the purposes of situations #5 and #6, no enrollment of an individual with an organization or provider described in #5 (1 through 6), or with a plan or in a program described in #6, may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which you first enrolled with such an organization, provider, plan or program.

Products to which Eligible Persons are Entitled:
The Medicare Individual Supplement Plan insurance policy to which Eligible Persons are entitled.

During Open Enrollment:
An Eligible Person may enroll in Aetna Individual Medicare Supplement Plan insurance policy A, B or F.

During Other Situations:

- Under situations #1, #2, #3 and #4 an Eligible Person may enroll in a Medicare supplement policy which has a benefit package classified as plan A, B or F.
- Under situation #5 an Eligible Person may enroll in the same Medicare supplement policy in which you were most recently previously enrolled, if available, or, if not so available, a policy described as plan A, B or F.
- Under situation #6 an Eligible Person may enroll in any Medicare supplement policy offered by Aetna Life Insurance Company.

Save yourself the time and trouble of bill paying…

Sign up for the **Aetna Electronic Funds Transfer Program** and your monthly Aetna Individual Medicare Supplement Plan℠ premium will be automatically withdrawn from your checking account or credit card account on the date it's due.

Who is eligible?

If you are covered by an Aetna Individual Medicare Supplement Plan insurance policy and have a credit card or checking account, you may apply.

When does it begin?

Billing starts on the seventh day of your next billing month (or the first business day thereafter if the seventh falls on a holiday or weekend). Please continue to send payments by mail until then. Ongoing premium payments will be withdrawn according to this schedule.

Why should I sign up?

The **Aetna Electronic Funds Transfer Program** helps you save on your costs for checks, envelopes and postage. Plus, you never have to worry about your plan premiums payment being late.

APPLY TODAY

Simply complete the attached application and return it to Aetna in the postage-paid envelope. You'll know your request has been processed when your first premium payment clears the account you selected. This generally happens within 30-60 days of sending in your application.

If you have questions about this offer, call: 1-800-557-5078. Or, for the hearing impaired (TTY/TDD), call: 1-888-200-6124. Please notify us of any account changes, including new expiration dates, during the call.

Please cut along dotted line

IMPORTANT – Please read and sign.

Terms of Agreement: I have an account at the financial institution named and, for all debit and charge entries, have funds sufficient to pay such entries. Electronic debit, charge or credit entries shall be initiated by Aetna to pay plan premiums and other charges for the listed health care policies or other policies as authorized, and the entries shall constitute my receipt for the transaction(s). No payment to Aetna shall be deemed to have been made unless and until Aetna receives final credit for the payment.

I also understand that if corrections to the entry are necessary, they may involve an adjustment to my account. I understand my direct electronic payment of the plan premium will be debited or charged on or after the premium due date, the first of every month.

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

Aetna Individual Medicare Supplement Plan policyholders must continue to pay their Part B premium and Part A if applicable.

Joint accounts require the signature of ALL persons having authority over the account. Please be sure all joint account holders sign below regardless of whether he/she is applying.

Signature: ____

Signature : ____

BILLING AUTHORIZATION APPLICATION

Policyholder's Aetna Individual Medicare Supplement Plan ID No:

____

Here's How to Apply:

1. Fill out the information below, where applicable
2. Choose a billing option.
3. If the deductions will be made from a checking account, please include a blank check marked "VOID" showing the preprinted account number.
4. Please be sure to sign this application.
5. Send to:

   Aetna Life Insurance Company
   P.O. Box 13547
   Pensacola, FL 32591-3547

YES! I'm applying for the Aetna Electronic Funds Transfer Program.

BILLING OPTIONS:

❑ Checking Account Option

Name(s) on Checking Account

____

____

Checking Account No.

____

❑ Credit Card Option

Name(s) on Card ______________________________________

Cardholder Address______________________________________

City ______________________ State__________ Zip __________

❑ VISA ™

❑ MasterCard™

Account No.____

Expiration Date____

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group or subsidiary companies. Health insurance plans are underwritten by Aetna Life Insurance Company. The Aetna Individual Medicare Supplement Plan is administered by CHCS Services, Inc.

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.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage coverage and replace it with a policy to be issued by Aetna Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the coverage.

You should review this coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this coverage.

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. If you still wish to terminate your present policy and replace it with the new coverage, be certain to truthfully and completely answer all questions in 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