aetna® Aetna AFA Medical and Stop Loss Application

	Employer DUNS Number	Instructions: You must complete the application fully and truthfully. You are solely responsible for its accuracy.

Employer Name	Effective Date	Date of Hire
ACEP Success Unlimited Policy # 0516155		

COBRA for: ☐ Employee ☐ Dependent **Length of Continuation:** ☐ 18 ☐ 36 ☐ Other ____ **Original Qualifying Event Date** _____ **Qualifying Event** _____

A. Employee Information

Last Name, First Name, M.I.	City, State	ZIP code

Number of Hours Worked Per Week 30 **Check One:** ☑ Full Time ☐ 1099 ☐ Seasonal ☐ COBRA ☐ Part Time ☐ Retired ☐ Temporary ☐ Union

B. Dependent Information – List any dependent living at another address.

Name	City, State, ZIP code	Name	City, State, ZIP code

C. Medicare Coverage – List individuals covered by Medicare.

Name of Person	Over Age 65	Disability	End-Stage Renal Disease Effective Date
	☐ Yes ☑ No	☐ Yes ☑ No	
	☐ Yes ☑ No	☐ Yes ☑ No	

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

(A)dd (C)hange (R)emove	Name (Last, First, M.I.)	Sex (M/F)	Birthdate (MM/DD/YYYY)	Height	Weight	Tobacco Use (including eCigarette devices)	Currently Taking Prescription Medication(s)	Incapacitated
	☐ Employee 1.					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Spouse ☐ Domestic Partner 2.					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Child ☐ Stepchild ☐ Other 3.					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Child ☐ Stepchild ☐ Other 4.					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Child ☐ Stepchild ☐ Other 5.					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

E. 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 professional 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), **circle** the applicable condition(s), and explain fully below.	
1. **Bone / Muscle**: Arthritis, Back/Neck/Spine problems, Joint disorders, Joint replacement, Herniated disc, Other. **Brain / Nervous:** Epilepsy (Seizures), Paralysis/Paresis, Pituitary disorder, Stroke, Other. **Heart / Circulatory:** Chest pain, Congestive Heart Failure, Heart Attack, Heart Disease, Hemophilia, High Blood Pressure, Sickle Cell Disease, Other. **Immune:** AIDS/HIV, Connective Tissue Disorder, Immunodeficiency, Systemic or Discoid Lupus, Other. **Intestinal / Endocrine**: Adrenal disorder, Cirrhosis, Crohn's, Diabetes Type I or Type II, Digestive disorder, GERD (reflux), Hepatitis B, C, or other, Liver or Pancreas disorder, Stomach ulcer, Ulcerative Colitis, Other. **Lung / Respiratory**: COPD, Emphysema, Other. **Substance Abuse**: Alcohol or Drug Abuse. **Reproductive**: Infertility, Pregnant-normal birth expected, Pregnant-high risk, Pregnant-multiple births expected, Other. **Transplant:** Organ or Bone Marrow Transplant (planned, recommended or already performed). **Tumor:** Fibroids (location), Other. **Urinary:** Bladder disorder, Dialysis, Kidney failure, Kidney stones, Other. **Other:** Birth defect/Congenital abnormality, Growth disorder (including Dwarfism or receiving growth hormones), Paralysis or Paresis, Prosthesis, Other.	☐ Yes ☐ No
2. Cancer: Type _____ Stage _____ **Check applicable boxes**: ☐ Surgery date _____ ☐ Chemo end date _____ ☐ Radiation end date _____	☐ Yes ☐ No
3. Is anyone applying for coverage been advised they need future hospitalization or have surgical procedures been planned, discussed, or recommended, or has any other medical condition which has not been disclosed? Provide full details below.	☐ Yes ☐ No

IF YOU ANSWERED "YES" TO ANY QUESTIONS, PLEASE EXPLAIN BELOW. (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 & Treatments	Start Date	End Date	Medications (include name and oral, injectable, or infusion)	Dosage	Is Treatment Ongoing? If YES, provide details of any current OR future treatment.

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.

I certify that all information and statements on this enrollment form are true and complete to the best of my knowledge and that I have authority to make statements on behalf of any dependents listed on this form. I am employed by the employer on page 1 and working full-time for this employer.

Employee Signature	Date