Please call and allow us to assist you with your application

1 800 721-2618

Avoid headaches and delays by allowing our office to assist you. You'll be surprised at how easy completing an application can be! Once your application is complete, please mail it to:

JustHealthplans.com
1344 Disc Dr. #210
Sparks, NV 89436

You may fax your application to: 844 309-8787

Thank you!

aetna®

Nevada 2017
Application for Aetna Individual Health Insurance

Aetna Life Insurance Company and Aetna Health Inc.

Primary Applicant's Name

Applicant's Social Security Number

INSTRUCTIONS:

- **Complete in blue or black ink only.**
- **PRINT clearly.**
- **All answers must be complete and truthful.**

IMPORTANT NOTES:

- **The information you provide is confidential.**
- **Intentional misrepresentation may result in the policy being modified or terminated.**
- **Proof of state residency may be required.**

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	County

Relationship (If Child-Only Application)

Mailing Address (If different from your Home address)

City	State	ZIP Code

Email Address

Telephone Number	If we need to call you with questions about your application, when is the best time to reach you?
Primary (_____)_____ **Secondary** (_____)_____	☐ Morning ☐ Afternoon ☐ Evening

Section B – Application Type

Application Type (Select one):	
☐ 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 the receipt date of your application.

Primary Applicant's Name

Section C – Enrollment Period

☐ **Annual Open Enrollment Period** (Annual period to enroll in medical coverage if no Special Enrollment Period applies. If you qualify for a Special Enrollment Period during the Annual Open Enrollment Period, coverage may start sooner.)

If you are applying outside of the Annual Open Enrollment Period and there is no qualifying event, please note there will be a 90-day waiting period from the time your application is received, until your effective date.

During this 90-day waiting period, you will not have coverage. Your plan does not pay benefits until your effective date.

☐ **Special Enrollment Period** (If you qualify for a Special Enrollment Period, you can enroll in medical coverage outside the Annual Open Enrollment Period. If you qualify for a Special Enrollment Period during the Annual Open Enrollment Period, coverage may start sooner.)

If one of the events listed below applies to you, check the appropriate box.

The Special Open Enrollment Period for the following events begins 60 days prior to the date of the event checked and continues for 60 days after.

Date of Event	Event
_____	☐ Loss of employer coverage due to termination of employment, reduction in hours, coverage no longer offered to my employment class, or expiration 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, death of policyholder, or policyholder enrolled in Medicare.
_____	☐ Loss of Medicaid or CHIP coverage.
_____	☐ Coverage needed following loss of eligibility for Exchange subsidies.
_____	☐ A permanent move.

The Special Open Enrollment Period for the following events begins on the date of the event checked and continues for 60 days.

_____	☐ Coverage needed for new dependent through marriage.
_____	☐ Coverage needed for new dependent through birth, adoption or placement for adoption.
_____	☐ Other, please explain. _____

Section D – Coverage Selection

Choose the plan that best meets your needs.
Silver:
HMO Plans
☐ Aetna Silver $15 Copay Health Network HMO PD
PPO Plans
☐ Aetna Silver $15 Copay PPO 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, with the youngest child listed first.

☐ Check here if you need more space 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 six (6) months, check "Yes" as Tobacco User below (This does not apply to applicants under the age of 18). Regular use means an average of four or more times per week.

If any person uses tobacco for religious or ceremonial purposes only, check "No" for Tobacco User below.

If choosing an HMO product for Medical (M), enter the primary care MD ID Number.

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

continued

Primary Applicant's Name

Section E – Persons Requesting Coverage (Continued)

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
How would you like Aetna to communicate with you regarding your application and coverage? ☐ Email ☐ 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.

Please note that there may be state or federal regulations that prohibit us from communicating with you in your preferred method.

Are any applicants enrolled in or entitled to Medicare benefits? ☐ Yes ☐ No

If Yes, provide name(s) of these applicants: _____

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

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

Proof of state residency will be required.

Name	Most recent arrival date

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

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

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

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 Form
By signing this form, I authorize Aetna, or Aetna's representatives, to pay a fee to a third party for certain protected health information (PHI) about me, including but not limited to, prescribed medication history or other pharmaceutical information, hospital records, physician and/or dentist records, claims or benefit records or lab results. The PHI purchased by Aetna may be used for the following purposes: a) to coordinate medical care and case management, and/or b) for risk adjustment activities.

PHI purchased by Aetna may be related to chronic diseases, mental illness, alcohol or substance abuse, Human Immunodeficiency Virus (HIV) infection, or Acquired Immune Deficiency Syndrome (AIDS).

I authorize Aetna to disclose my PHI for the purposes stated above to other persons or organizations performing services on Aetna's behalf.

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.

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

Right to Revoke
I understand that I may revoke this authorization at any time by giving written notice to Aetna using the address provided in Section J. 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 / 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 and belief.
2. The children listed on this application are my legal 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, and may face legal liability, including legal action based on fraud.
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.

Primary Applicant's or Parent/Guardian's Signature	Date
Spouse / 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 I – Insurance Producer or Agent (Required If Applicable)

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

Print Name of Producer Gary Jackson	NPN of Agent 20-4235083
Signature of Producer (required if applicable)	Telephone Number ( ) 1 800 721-2618
Email Address service2@justhealthplans.com	Fax Number ( ) 844 309-8787
Street Address (Street, Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code) 1344 Disc Dr. #210 Sparks, NV 89436	

Complete if Broker of Record is an Agency

Name of Agency	TIN of Agency	
Email 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

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call (855) 208-4606.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

For language assistance in English call 855.208.4606 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 855.208.4606. (Spanish)

欲取得繁體中文語言協助，請撥打 855.208.4606，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 855.208.4606 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 855.208.4606 nang walang bayad. (Tagalog)

T’áá shí shizaad k’ehjí bee shíká a’doowoł nínízingo Diné k’ehjí koj̨į’ t’áá jíík’e hólne’ 855.208.4606 (Navajo)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 855.208.4606 an. (German)

በ አማርኛ የቋንቋ እገዛ ለማግኘት በ 855.208.4606 በነጻ ይደውሉ (Amharic)

(Acij ak* .855.208.4606 لم-Y´عذة في (اللغةلاغغيت(لماغO¹Hالاس Y ل على الرقم المجاني

Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 855.208.4606 ku busa. (Bantu-Kirundi)

বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 855.208.4606-তে কল করুন। (Bengali–Bangala)

ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 855.208.4606 ကို ခေါ်ဆိုပါ။ (Burmese)

ᎾᏍᎾᏚᏆᏍᏛᏗ ᏗᏂᏍᏈᎵᏍᏛ ᎾᎦᎢ (ᏣᎳᎩ) ᏬᏏᏔᏕᏚ 855.208.4606 ᏅᏯᎢ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᏗᏂᏑᏒᎾ. (Cherokee

Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 855.208.4606 irratti bilisaan bilbilaa. (Cushite)

Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 855.208.4606. (Dutch)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 855.208.4606 gratis. (French Creole)

Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 855.208.4606 χωρίς χρέωση. (Greek)

(Gujarati) ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 855.208.4606 પર કૉલ કરો.

(Hindi) हिन्दी में भाषा सहायता के लिए, 855.208.4606 पर मुफ्त कॉल करें।

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 855.208.4606. (Hmong)

Maka enyemaka asụsụ na Igbo kpọọ 855.208.4606 na akwụghị ụgwọ ọ bụla (Ibo)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 855.208.4606. (Italian)

日本語で援助をご希望の方は、855.208.4606まで無料でお電話ください。(Japanese)

လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၢ် ကျိာ် ကိး 855.208.4606 လၢတအိာ်ဒီးတၢ်လၢာ်ဘူာ်လၢာ်စ့ၤဘၣ် (Karen)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 855.208.4606번으로 전화해 주십시오. (Korean)

Ɓɛ́ m̀ ké gbo-kpá-kpá dyé pídyi ɖé Ɓăsɔ́ɔ̀-wùɖùǔn wɛ̃ɛ, ɖá 855.208.4606 (Kru-Bassa)

(Kurdish) [illegible] 855.208.4606- [illegible]

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 855.208.4606 ໂດຍບໍ່ເສຍຄ່າໂທ. (Laotian)

សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 855.208.4606 ដោយឥតគិតថ្លៃ។ (Mon-Khmer, Cambodian)

(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 855.208.4606 मा फोन गर्नुहोस् । (Nepali)

Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 855.208.4606 kecïn aɣöc. (Nilotic-Dinka)

For språkassistanse på norsk, ring 855 208 4606 kostnadsfritt. (Norwegian)

(Panjabi) ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 855.208.4606 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Fer Helfe in Deitsch, ruf: 855.208.4606 aa. Es Aaruf koschtet nix. (Pennsylvanian Dutch)

(Persian) [illegible] 855.208.4606 [illegible] برای

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 855.208.4606. (Polish)

Para obter assistência linguística em português ligue para o 855.208.4606 gratuitamente. (Portuguese)

Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 855.208.4606 (Romanian)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 855.208.4606. (Russian)

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 855.208.4606. (Serbo-Croatian)

Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 855.208.4606. Njodi woo fawaaki on. (Sudanic-Fulfulde)

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 855.208.4606 bila malipo. (Swahili)

ܫܘܝܐ ܫܠܚ ܡܬܪܓܡ ܒܝܕ ܟܬ ܠܝ

ܟܠ ܡܬܪܓܡ ܐܡܝܢ ܒܠܫܢ ܐܡܐ ܠ855.208.4606 ܡܟܝ. (Syriac-Assyrian)

భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 855.208.4606కు కాల్ చేయండి. (తెలుగు) (Telugu)

สำหรับความช่วยเหลือทางด้านภาษาเป็นภาษาไทย โทร 855.208.4606 ฟรีไม่มีค่าใช้จ่าย (Thai)

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 855.208.4606. (Ukrainian)

اُردو میں مدد کے لیے 855.208.4606 پر مفت کال کریں۔ (Urdu)

Để được hỗ trợ ngôn ngữ b ng (ngôn ngữ , hã gọ miễ phí đến số 855.208.4606. (Vietnamese)

פאר שפראך הילף אין אידיש רופט 855.208.4606 פריי פון אפצאל.)Yiddish(

Fún ìrànlọwọ nípa èdè (Yorùbá) pe 855.208.4606 lái san owó kankan rárá. (Yoruba)