Evidence of Insurability Statement for Medical and Dental Coverages

Aetna International

Coverage underwritten by Aetna Life Insurance Company and Aetna Life & Casualty (Bermuda) Ltd.
Visit us at www.AetnaInternational.com

Read This Instruction Page Carefully.

Guidelines

Evidence of Insurability is required if one of the following applies to you:

- You are a member of a group that does not meet minimum group size requirements*;
- You did not request coverage within the eligibility period for your employer's group Plan of Benefits*;
- You have requested reinstatement of coverage which you previously discontinued;
- You have Major, Comprehensive, or PPO Medical Coverage in force and you wish to reinstate the maximum;
- You have requested an increase in any coverage.

* Evidence of Insurability will not be required for these reasons for medical coverage that is underwritten through Aetna Life Insurance Company, although such members who do not request coverage within the eligibility period of their employer's group Plan of Benefits may be required to wait to enroll until an annual late entrant enrollment period. See your Employer for details.

Please Note: Additional information (including a medical exam) will be required along with the Evidence of Insurability Statement under the following circumstances:

- The individual(s) applying for coverage is (are) age 60 or over and is (are) applying for coverage underwritten through Aetna Life & Casualty (Bermuda) Ltd.

** Aetna reserves the right to contact you directly to request additional information upon receipt of this completed Statement.

Instructions

1. Employer

Please Print

- Complete Section A in its entirety. *Be sure that*:
  - All items are completed.
- The Control Number, Suffix and Account numbers are provided (A1).
  - The employee's **Social Security/Employee Identification Number** is provided (A2).
  - Both the employee's and your address are shown in the spaces provided (A3 and A4).
  - The telephone number of your Authorized Representative (A5), employee's date of hire (A6), the employee's home and work telephone numbers (A7), are provided.
  - General information on the employee's sick days for the current and previous year(s) (A8) are provided.
  - Check the boxes for the Coverages being requested and the individuals requesting coverage (A9). Be sure to provide the current amount of coverage, requested increase amount, and the resulting total amount of coverage for each individual for whom coverage is being requested. The applicable reason coverage is being requested should also be checked off.
  - Section A is signed by your Authorized Representative.
- Give the form to your employee for his/her confidential submission to Aetna.
- Aetna will advise you of its coverage decision.

2. Employee

Read the Privacy Notice and Misrepresentation section on page 4 before completing.

Please note: Failure to disclose information – as detailed in the Misrepresentation section – may also adversely impact your ability to participate in the Plan.

Please Print

- Verify that your address and **Social Security/Employee Identification Number** as shown in Section A are complete and accurate. We may need to direct additional inquiries to your attention.
- Complete Section B. ***Be sure that***:
  - All copies are legible.
  - All items are completed.
  - Complete dates and details are given for all "No" answers to questions B1a, B1b, and B1c and for all "Yes" answers and/or medical/dental impairments checked (in Sections B2-B4).
  - Only the names of individuals requesting coverage at this time are listed (B1). Check appropriate boxes regarding dependent child coverage, if applicable (B1a, B1b, and B1c).
  - Height and Weight must be provided or this form will be returned unprocessed for your completion (B1)
  - The form is signed by you. If you are requesting spouse coverage, the spouse's signature is also required. Please read the Certification, Acknowledgement, and Authorization prior to signing the form (bottom of Section B).
- Please make a copy for your records. Fax or mail the **original** to:

  Aetna International – Medical Underwriting
  151 Farmington Avenue – RE4K
  Hartford, CT 06156-0102
  Facsimile: +1-860-975-1563

If a final underwriting decision cannot be made within six months, Aetna reserves the right to request a new Evidence of Insurability Statement. Please Note: If this form is not completed in its entirety *and* signed, it will be returned unprocessed for your completion.

Privacy Notice - Insured Plans Only

In evaluating your insurability, we (Aetna) will rely primarily on the health information you furnish to us in this Evidence of Insurability Statement. In addition, however, we may ask you to take a physical examination, or request additional medical information about you from any of the sources specified in the authorization on the front of this form.

Disclosure of Information to Others

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. For example, Aetna Life Insurance Company may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may apply for coverage, or to whom a claim for benefits may be submitted. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding), and to request correction, amendment or deletion of recorded personal information in states which provide such rights and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right, or if you wish to have a more detailed explanation of our information practices, please contact:

Aetna International – Medical Underwriting, 151 Farmington Avenue – RE4K, Hartford, CT 06156-0002. Facsimile: +1-860-975-1563

Under New Mexico law, a resident of New Mexico has the right to register as a “protected person” in connection with disclosure of confidential domestic abuse information. If you wish to exercise this right, contact the Member Services number on your ID Card, or write to the address shown above.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially 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.

Attention Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention California Residents**: For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Attention Colorado Residents**: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents**: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** Any person who knowingly and with intent to **defraud** any insurance company or other person files a statement of claim containing any materially **false** information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a **crime**. **Attention Louisiana Residents**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. **Attention Maryland Residents**: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention Missouri Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, denial of insurance and civil damages, as determined by a court of law. Any person who knowingly and with intent to injure, defraud or deceive an insurance company may be guilty of fraud as determined by a court of law. **Attention New Jersey Residents**: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **Attention North Carolina Residents**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties. **Attention Ohio Residents**: Any person who, with intent to defraud or knowing he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Attention Oklahoma Residents**: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Attention Oregon Residents**: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Pennsylvania Residents**: 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 materially 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. **Attention Puerto Rico Residents**: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Texas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Vermont Residents**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties. **Attention Washington Residents**: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. **Attention New York Residents**: 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 materially 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Signature ____________________ Date ____________________

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A. Employer: Complete this Section – Please print clearly.

1. **Control Number** **Suffix** **Account**

2. **Employee's Social Security/Employee Identification Number**

3. Employer's Name and Address
____
____
Street
____
City State/Country ZIP Code

4. Employee's Name and Address
____
____
Street
____
City State/Country ZIP Code

5. Employer Authorized Representative's Telephone Number (include country code, as applicable)
( )

6. Employee's Date of Hire (Month, Day, Year)

7. Employee's Telephone Numbers (include country code, as applicable)
Work ( ) ______________________
Home ( ) ______________________

8. This employee's sick days this calendar year to date are _____; in the last full calendar year the total was ____________;
(or if worked less than 52 weeks indicate sick days _________ and weeks worked ____________________________).

9. Application Applied for:
☐ Medical: ☐ Employee ☐ Spouse ☐ Dependents
☐ Dental: ☐ Employee ☐ Spouse ☐ Dependents

***Reason for Requested Coverage:** ☐ Salary Increase* ☐ Change in Multiple* ☐ Other (Please explain) __________________
☐ New Employee Requesting an Amount in Excess of the Non-Medical Maximum(s)*
☐ Lifestyle/Status Change* ☐ Late Applicant
Scheduled Benefit $ ________________ or ___________ %
☐ Initial Coverage: Requested Benefit % is ____________________________ ☐ Higher Plan Option: Present Benefit % is ___________
Requested Benefit % is _________

10. **I certify the above information is correct.**
Employer - Authorized Representative's Signature ____ Date Signed ____________
Employer - Authorized Representative's Name (Please print) ____

B. Employee: Complete this Section - Please print firmly to make clear copies.

1. Only the Names of Individual(s) Requesting Coverage at this Time Should be Listed.

Name	Relationship	Birthdate *(mm/dd/yyyy)*	Birth Place (City, State/Country)	Sex	Height *(ft., in.)*	Weight *(lbs)*
Employee:	Self					
Spouse:						
Dependent(s):						

Complete these questions if dependent children are listed above. Give dates and details for "**No**" answers using the space provided in Number 5.

	Yes	No	
a.	☐	☐	Do all dependent children live in your household?
b.	☐	☐	Do all dependent children depend on you solely for support?
c.	☐	☐	If any dependent child is age 19 or older, is/are they regularly attending school?

2. Statement of Health for Individual(s) Listed Above. Give complete dates and details for "**Yes**" answers using the space provided in Number 5.

	Yes	No	
a.	☐	☐	Is any individual pregnant?
b.	☐	☐	Are any inpatient or outpatient medical/surgical or dental procedures or oral surgery (including diagnostic testing) recommended or contemplated?
c.	☐	☐	Is any individual currently taking medication(s) for any condition? If "Yes," list individual(s), medication and dosage, and indicate duration of use and underlying condition/diagnosis.
d.	☐	☐	Do you use tobacco products (includes cigarettes, cigar, pipe, and chewing tobacco)? (If they include cigarettes, indicate packs per day _________ and number of years smoked _________.)

	Yes	No	Within the Past	Has Any Individual:
e.	☐	☐	5 Years	Been examined by, consulted with, or received medical treatment from any physician, dentist or practitioner? If "Yes," please explain.
f.	☐	☐	5 Years	Been confined in a hospital, clinic, sanitarium or other treatment facility? If "Yes," please explain.

B. Employee: Complete this Section (Continued) - Please print clearly.

2. Statement of Health - Continued. Give complete dates and details for **all** medical impairments checked using the space provided in Number 5.

i. Yes ☐ No ☐ Within **past years,** has there been any disease/impairment of or treatment for any individual for any of the following?
If "**Yes**," check appropriate box(es) below and explain. If you have experienced a medical impairment that is *not* listed below, please check the "Other" box and list/explain the impairment in the space provided in Section 5

☐ AIDS/AIDS Related Complex	☐ Carpal Tunnel Syndrome	☐ Infertility Treatment	☐ Reproductive System Disorder
☐ Alcoholism	☐ Congenital Abnormalities	☐ Intestines	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Diabetes	☐ Kidney/Bladder	☐ Seizures
☐ Arthritis	☐ Digestive System Disorder	☐ Liver	☐ Skin
☐ Asthma	☐ Ears	☐ Lungs	☐ Stroke
☐ Back/Spine/Neck	☐ Epilepsy	☐ Mental/Nervous Disorder	☐ Substance Abuse
☐ Blood Pressure/Hypertension	☐ Eyes	☐ Multiple Sclerosis	☐ Surgical Operation
☐ Blood Vessels	☐ Gastrointestinal Disorder	☐ Muscular System Disorder	☐ Thyroid
☐ Bones	☐ Heart	☐ Nervous System	☐ Tumor/Growth
☐ Brain	☐ Hernia	☐ Paralysis	☐ Ulcer
☐ Cancer	☐ Immune System Disorder	☐ Premature Birth	☐ Other

3. DENTAL COVERAGE: If Dental coverage is not available from Aetna through your employer's Plan of Benefits, please do not complete this section. If coverage is available, a recent dental exam (i.e., within the past 12 months) is required before you can be considered for dental coverage.

Please indicate if there is an oral/dental condition(s) needing treatment by an individual requesting coverage. Give details for "**Yes**" answers using the space provided in Number 5. If no treatment is necessary, check "None" box. ☐ NONE

	Yes	No			Yes	No	
a.	☐	☐	Any fillings needed? If "**Yes**," how many? ____________	**f.**	☐	☐	Any teeth needing extraction?
b.	☐	☐	Any crowns needed?	**g.**	☐	☐	Periodontal disease needing treatment?
c.	☐	☐	Any denture/bridgework needed?	**h.**	☐	☐	Any orthodontic treatment needed?
d.	☐	☐	Missing teeth needing replacement?	**i.**	☐	☐	Any surgery needed?
e.	☐	☐	Periapical disease (i.e., root canal) needing treatment?	**j.**	☐	☐	Other ____________
k.	☐	☐	Have all individuals had a dental exam within the past 12 months? If "**No**," give details.				

4. ☐ ☐ Does any individual(s) have a known physical impairment(s) or ill health not mentioned in Numbers 2 and 3? If "**Yes**," give complete dates and details.

5. Use this space to provide the details for "**No**" answers **in Number 1** and "**Yes**" answers ***and/or*** **medical impairments checked in Number 2 - 4**. Be specific as to individual(s) affected. **Indicate the number being answered (and letter, as applicable) and provide Names, Dates, Details, Diagnosis and Treatment**.

Ques No.	Name	Dates	Details	Diagnosis	Treatment	Date of Full Recovery

☐ *Check here if you are providing additional information on a separate attachment.*

Certification: I certify these answers and statements are complete and true to the best of my knowledge and belief. I will inform Aetna of any material changes to the information provided which take place between the time the form is completed and the time coverage becomes effective. I agree that this document shall form a part of my request for group coverage and I acknowledge that I have been given a copy of this document as completed by me.

Acknowledgment: I understand that, to the extent permitted by state law, false statements may result in the denial of claims or in my insurance coverage being void as of its effective date with no benefits payable. I understand that conditions which are disclosed on this form may be subject to all conditions of my employer's Plan including any preexisting condition limitations, fraud provisions, employee actively at work and dependent health condition requirements. My signature indicates that I have reviewed all information and statements on this form for completeness and accuracy.

Authorization: To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical or hospital service and prepaid health plans, and employers: You are authorized to provide Aetna Life Insurance Company, Aetna Life & Casualty (Bermuda), Ltd., or any of their affiliates (hereinafter referred to as "Aetna"), information concerning health care, advice, treatment or supplies (including those related to mental illness and/or AIDS/ARC/HIV) provided me or any members of my family for whom coverage has been requested. (Minnesota residents are not required to provide information concerning results of AIDS/ARC/HIV tests performed on a criminal offender or a crime victim.) I acknowledge that information obtained from any or all of the above may result in further underwriting investigation. This information will be used for the purpose of determining eligibility for coverage. This authorization will be valid for thirty (30) months from the date signed (Minnesota residents twelve (12) months).

I acknowledge that I have read the Privacy Notice and Misrepresentation Section on page 4 of this form and know that I have a right to receive a copy of this authorization upon request. I agree that a reprographic copy or a facsimile copy of this authorization is as valid as the original.

_______________________________________ ______________
Employee's or Authorized Person's Signature *(Employee must sign at all times.)* Date Signed

_______________________________________ ______________
Spouse's or Authorized Person's Signature *(Spouse must sign when spouse coverage is requested.)* Date Signed

C. Aetna's Acknowledgment to Employer

☐ **APPROVED**. Effective ____/____/____. If Aetna is maintaining your records, please submit the appropriate Enrollment/Change form.

☐ **NOT APPROVED** for ______________________________ . **Employee has been advised.**

☐ Since the employee's benefits are not approved, dependent coverage will not be issued.

By: ______________________________ ____/____/____
Medical Underwriting Unit Date

For Plans Compliant with United States Federal Affordable Care Act (ACA) legislation
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 the number on your ID card.

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

English	**To access language services at no cost to you, call the number on your ID card.**
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Persian Farsi	**برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.**
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.