HSA *for* America No-Hassle Application Instructions

1. Print all pages of the application including instructions.
2. Complete all questions and sections of the application.
3. Complete the mail/fax cover letter on the next page and fax to **HSA *for* America** for review, along with the completed application. If you do not have access to a fax machine, mail the completed application to **HSA *for* America** 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.

- Make sure you answer all questions.
- Indicate your requested effective date.
- Indicate your plan name and deductible.
- Select your preferred billing method, including method of payment for initial premium. If you are paying by check, make check payable to: **Aetna**
- Make sure you provide a complete medical history, including medications, dates of treatment, and doctor or hospital.
- Please be sure to sign and date the application everywhere it is requested.

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 sign and date the authorization form.

If you are faxing your application, please don't forget to **include a credit card number or bank draft authorization to cover the first month's premium**. Fax your completed application to **866-284-0082**, or mail the application and check or credit card authorization to:

HSA *for* America
Attn: New Enrollment
1001-A E. Harmony Rd. #519
Fort Collins, CO 80525

HSA *for* America will review your application for completeness and accuracy before we submit it to the insurance company for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

HSA *for* America

MAIL or FAX COVER LETTER

Please include this form when mailing or faxing your completed application. If you are paying by check, please make check payable to:

Aetna

Fax Toll Free to: **866-284-0082**

Mail to: **HSA *for* America**
Attn: New Enrollment
1001-A E. Harmony Rd. #519
Fort Collins, CO 80525

Dear **HSA *for* America**,

Please accept my completed insurance application for submittal and contact me to confirm receipt. I understand that you will regularly keep in touch with the insurance company's underwriting department, keep me informed of the status of the application on a weekly basis, and let me know when I've been approved. I will have 10 days to review the policy, and if for any reason I decide not to keep the policy during that time period I understand I am entitled to a full refund.

Name:	
E-mail:	
Plan:	
Deductible:	
Premium:	
Requested Effective Date:	
Current Date and Time:	

(We will email you to verify receipt of your application. You may reach us at **info@HSAforAmerica.com**, or call us toll free at **800-707-9849**.)

Aetna Advantage Plans for Individuals, Families and Self-Employed* - OK

Applicant's Social Security Number

Application ID Number

Instructions:
- Application must be completed by the applicant in blue or black ink. **(A photocopy of this Application will not be accepted.)**
- **This Application must be completed in its entirety and one (1) form of payment selected or processing time will be delayed.**
- Signature and date is required on **Page 5, Section K** for all applicants including spouse and children age 18 and over.
- PPO products are underwritten by Aetna Life Insurance Company.
- Any family member currently pregnant (whether or not listed on this Application) or in the process of adoption or surrogacy does not qualify for this program.

Send completed Application to:
Aetna Advantage Plans, F230
P.O. Box 61516
King of Prussia, PA 19406-0916

Aetna Use Only Y – N – U	Effective Date:	Number:

A. Applicant Information

Name

Maiden Name of Applicant/Spouse

Mailing Address (All Aetna correspondence will be sent to this address) – Include Apartment Number, if applicable.
Number, Street ______
County ______
City, State, ZIP Code ______

Telephone Numbers
Home ( )
Work ( )
Cell ( )

Billing Address (if you prefer your bill to be mailed to a different address than listed above.) - Include Apartment Number, if applicable.
Number, Street ______
City, State, ZIP Code ______

Marital Status
☐ Single ☐ Married

Occupation

E-mail Address

Please check if applicable:
☐ I am not eligible for health benefits offered by my employer
☐ I am a sole proprietor or I am self-employed

Do you read and write English? ☐ Yes ☐ No

Choose desired benefit plan type:
Managed Choice Open Access:
☐ 1500 ☐ 2500 ☐ 5000
☐ Managed Choice Open Access First Dollar 35
☐ Managed Choice Open Access Value 2500
☐ High Deductible MC OA 3000 (HSA Compatible)
☐ High Deductible MC OA 5000 (HSA Compatible)
☐ Preventative and Hospital Care 1250
☐ Preventative and Hospital Care 3000 (HSA Compatible)
☐ Dental (Dental option available only with choice of medical plan above.)

Reason for Application Form:
☐ New Application
☐ Add Spouse/Dependent Child to an Existing Plan
☐ Add Dependent Child Only to an Existing Plan
☐ Change Existing Benefit Plan

Is any person listed on this Application a "non-citizen resident" of the United States? ☐ Yes ☐ No

If "Yes," has that person(s) resided within the United States for the past six (6) consecutive months? ☐ Yes ☐ No

If "No," provide the name(s) and explanation.

B. Individuals Covered *(Dependent children are covered up to age 23.)*

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

Family Code*	Name Last	First	M.I.	Social Security Number	Date of Birth (MM / DD / YYYY)	Age	Sex (M/F)	Height (ft / in)	Weight (lbs)
APP	Applicant								
SP	Spouse								
01	Dependent								
02	Dependent								
03	Dependent								

C. Other Insurance - Please attach copy of Continuation of Coverage Certificate letter for each applicant, if applicable

Are you replacing existing coverage? ☐ Yes ☐ No

Do you currently have any health care coverage? ☐ Yes ☐ No

Are your spouse/children covered also? ☐ Yes ☐ No

Has any applicant ever filed a claim and/or received benefits from disability insurance or Workers' Compensation? ☐ Yes ☐ No
If Yes, provide dates and details

Are any family members listed above currently enrolled in an Aetna Advantage Plan? ☐ Yes ☐ No
If Yes, provide names and relationship: ______ ID# ______

Provide name of current (or most recent) health care carrier and coverage termination date (if applicable).
Name ______ Term Date ______

Has any applicant listed on this Application ever been declined, postponed, had a waiver applied or charged an additional premium for life, disability or health insurance or had such insurance rescinded? ☐ Yes ☐ No If Yes, provide the following information:
Applicant Name: ______ Explanation: ______

Applicants who are currently covered by another carrier must agree to discontinue the other coverage prior to or on the effective date of the Aetna Advantage Plan.
☐ Yes ☐ No
If No, explain: ______

Are any applicants listed above eligible for Medicare? ☐ Yes ☐ No
Applicant Name: ______ Applicant Name: ______

***In some states, the Self-Employed can purchase a guaranteed issue group insurance plan under Small Group Reform.**

Applicant's Social Security Number

Application ID Number

D Health History for Applicant and ALL Dependents *(Include information for all persons applying for coverage.)*

Answer all questions & provide complete details to all "Yes" answers on Page 3, Section F. **Missing information may delay processing this Application.**

In the past five (5) years, has any person listed on this application been diagnosed or treated by a health care provider (including prescription medications) or been hospitalized for any of the following conditions or diseases listed in Sections D and E?

D1.	**Eyes, Ears, Nose and Throat Conditions/Disorders:** *Eyes/sight:* glaucoma, cataracts, crossed eyes, detached retina, corneal transplant, infections; *Ears/Hearing:* loss of hearing, deafness, infections, eustachian tube dysfunction; *Nose/breathing:* deviated septum, polyps, adenoiditis, sinusitis; *Throat/Swallowing:* tonsillitis, strep throat, excessive snoring or sleep apnea?	☐ Yes ☐ No
D2.	**Skin Conditions/Disorders:** Acne, birthmarks, dermatitis, eczema, fungal infections, psoriasis, keratosis, warts, moles, pre-cancerous lesions, skin cancer or melanoma, 2nd or 3rd degree burns, herpes, scars/keloid, or revisions of cosmetic or reconstructive surgery, excessive sweating?	☐ Yes ☐ No
D3.	**Musculoskeletal Conditions/Disorders:** Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as strain/sprain, fracture, arthritis, fibromyalgia, gout, herniated disc, joint replacement, internal/external fixations, permanent hardware, amputation/prosthesis?	☐ Yes ☐ No
D4.	**Respiratory Conditions/Disorders:** Allergies, sinusitis, bronchitis, asthma, pneumonia, shortness of breath, chronic cough, collapsed lung, emphysema, COPD, tuberculosis, fungal infections, difficulty breathing, spitting/coughing up blood?	☐ Yes ☐ No
D5.	**Digestive Conditions/Disorders:** Infections of mouth/throat/tonsils, problems with jaw or chewing, ulcers, hernia, gastric reflux, colitis, Crohn's Disease, Irritable Bowel Syndrome (IBS), chronic diarrhea, intestinal problems, colon polyps, rectal bleeding or hemorrhoids, diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, jaundice, Cirrhosis, unexplained weight loss or gain, eating disorder, Gastric Bypass/Banding?	☐ Yes ☐ No
D6.	**Urinary Conditions/Disorders:** Bladder infections, kidney infections, stones, blood in urine, stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting?	☐ Yes ☐ No
D7.	**Heart and Circulatory Conditions/Disorders:** Anemia, bleeding/clotting disorders, Hemophilia, thrombocytopenia, varicose/spider veins, Raynauds, phlebitis, thrombosis, enlarged lymph nodes or lymphadenitis, chest pain, angina, high/low blood pressure, hypertension, high cholesterol/lipids, heart murmur, palpitations, congestive heart failure, coronary artery disease, aneurysm, heart attack, bypass surgery/angioplasty, valve replacement, pacemaker or defibrillator, rheumatic fever?	☐ Yes ☐ No
D8.	**Metabolic and Endocrine Conditions/Disorders:** Diabetes, adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis, thyroid disorders, AIDS/ARC (not including the result for the HIV test), or other immune disorders?	☐ Yes ☐ No
D9.	**Brain/Nervous System Conditions/Disorders:** Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, confusion, memory loss, Alzheimer's, dementia, head injury, stroke, migraine headaches or chronic severe headaches, narcolepsy, sleep apnea, tremors, Multiple Sclerosis, seizures/epilepsy, Muscular Dystrophy, Reflex Sympathetic Dystrophy (RSD)?	☐ Yes ☐ No
D10.	**Male Reproductive Conditions/Disorders:** Fertility/infertility, low sperm count, sexual dysfunction, erectile dysfunction, enlarged prostate, prostatitis, undescended testes, genital or anal herpes/warts or sexually transmitted diseases?	☐ Yes ☐ No
D11.	**Female Reproductive Conditions/Disorders:** a) Pelvic pain, abnormal, menstrual bleeding, absence of menstruation, abnormal PAP smear, endometriosis, ovarian cysts, uterine fibroids, fertility/infertility, miscarriage, breast cysts/lumps/fibroids, breast implants, genital warts/herpes or sexually transmitted diseases?	☐ Yes ☐ No
	b) Has it been more than 40 days since any female listed above had her last menstrual period? If Yes, provide name(s) and reason: Name ______ Reason ______ Name ______ Reason ______	☐ Yes ☐ No
	c) Has any ***female*** had an abnormal PAP Smear? If Yes, provide details in **F1.** Date of last normal PAP Smear: Applicant Name ______ Date ______	☐ Yes ☐ No
	d) Is any ***female*** applicant pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate? If Yes, provide name: Applicant Name ______	☐ Yes ☐ No
D12.	**Nervous, Mental and Behavioral:** Depression, anxiety, attention deficit, chemical imbalance, bi-polar, obsessive-compulsive or panic disorders, substance abuse, eating disorders, counseling or support group, alcohol or chemical dependence, anorexia/bulimia, schizophrenia?	☐ Yes ☐ No
D13.	**Cancer/Tumors:** Cysts, tumors or abnormal growths, Hodgkin's disease, leukemia or any other cancer or malignancy?	☐ Yes ☐ No
D14.	**Birth Defects/Congenital Abnormalities:** Birthmarks, cleft palate/lip, club foot, webbed fingers/toes, developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation, skull /facial or other physical deformities, Cerebral Palsy?	☐ Yes ☐ No
D15.	**Other Conditions:** Has any applicant consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s) not listed on this Application?	☐ Yes ☐ No

NOTE: Medical conditions that occur after the signature date and before the effective date of the coverage if approved will be considered in the final underwriting decision. You shall communicate any medical condition occurring during such period.

Applicant's Social Security Number

Application ID Number

E. Health Related Questions *(Include information for all persons applying for coverage.)*

Answer all questions & provide complete details to all "Yes" answers on Section F below.	Missing information may delay processing this Application.	
E1.	Is any ***male*** applicant expecting a child or in the process of adoption or surrogacy with anyone whether or not that person is applying for coverage on this Application? If Yes, provide applicant name below. Applicant Name: ______	☐ Yes ☐ No
E2.	Has any applicant been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? If Yes, provide applicant name(s) below. Applicant Name: ______ Applicant Name: ______	☐ Yes ☐ No
E3.	Has any applicant ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal or controlled IV drugs? If Yes, provide applicant name(s) below. Applicant Name: ______ Type of Drug/Substance: ______ Date Discontinued: ______ Applicant Name: ______ Type of Drug/Substance: ______ Date Discontinued: ______	☐ Yes ☐ No
E4.	Has any applicant consumed any alcoholic beverage in the last 6 months? (Amount: A drink is 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor.) Applicant Name: ______ Type: ______ Amount: ______ per ☐ Day ☐ Week ☐ Month Applicant Name: ______ Type: ______ Amount: ______ per ☐ Day ☐ Week ☐ Month	☐ Yes ☐ No
E5.	Has any applicant been convicted of a DUI (drunk driving violation)? If Yes, provide applicant name(s), state(s) and dates. Applicant Name: ______ State: ______ Date: ______ Applicant Name: ______ State: ______ Date: ______	☐ Yes ☐ No
E6.	Has any applicant been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), diseases associated with AIDS or other immune system disorders, or ever tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No
E7.	Has any applicant had any ***abnormal*** lab results, X-rays, MRI or other diagnostic test results or physical exam results?	☐ Yes ☐ No
E8.	Has any applicant been medically advised to undergo further medical testing, treatment or surgery which has not yet been completed?	☐ Yes ☐ No
E9.	Has any applicant been a patient in an outpatient clinic, hospital, surgical center, treatment center or other medical facility?	☐ Yes ☐ No
E10.	Has any applicant seen any health care provider for any condition, signs, or symptoms which have not yet been diagnosed?	☐ Yes ☐ No
E11.	Has any applicant smoked or used tobacco products, such as Snuff and/or chewing tobacco, in the last 2 years? If Yes, Provide Applicant(s) below. Applicant Name: ______ Date Stopped: ______ Applicant Name: ______ Date Stopped: ______	☐ Yes ☐ No
E12.	Has any applicant taken prescription medications or been advised to take prescription medications in the last 2 years?	☐ Yes ☐ No
E13.	Has any applicant ever seen, received treatment from, or consulted any health care provider for any other condition or symptom(s) not listed on this Application?	☐ Yes ☐ No
E14.	Is any applicant a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	☐ Yes ☐ No
E15.	Is any applicant currently on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	☐ Yes ☐ No

F. Detailed Health Information

☐ ***Check here if additional space is needed. Use a separate sheet of paper and staple to the back of this Application.***

1. Provide COMPLETE DETAILS to ALL questions answered "Yes" in Sections D and E.

Family Code*	Ques. No.	Dates From	To	Explain Nature of Illness/Condition	Describe Treatment Received/Recommended and Any Limitations if Applicable	% of Recovery

2. List all prescription medications and/or doctors' samples taken by you and/or your named dependents within the last 2 years.

Family Code*	Ques. No.	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Name of Medication	Dosage and Frequency	Reason/Condition

***See Page 1, Section B.**

Applicant's Social Security Number

Application ID Number

F. Detailed Health Information (Continued)

3. For details and medications indicated above, please list ALL doctors, medical attendants, or practitioners you and/or any named dependents consulted. If None, please state "None."

Family Code*	Question Number and/or Reason	Name, Address and Phone Number of Attending Physician

4. List last doctor visit for all family members, including routine check-ups.

Family Code*	No Visit	Purpose of Visit	Date of Visit	Results of Visit		Name, Address and Phone Number of Physician
				Normal	Abnormal: Give Details	
APP						
SP						
01						
02						
03						

***See Page 1, Section B.**

G. Statement of Application Conditions

Each member of the family will be medically underwritten separately and assigned a separate medical coverage based on their own health risk.
If one or more family members are not approved, Aetna will cover the approved family members unless otherwise indicated below.

☐ I, the applicant, instruct Aetna not to cover any eligible family members unless all family members are approved for coverage.

☐ I prefer to receive written communication regarding my Application via email.

H. Race/Ethnicity - Optional

Family Code	(This information is designed for the purpose of data collection and will not be used for determining eligibility, rating, or claim payment.)	01	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian– 04 ☐ Other – 05 ____________
APP	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian– 04 ☐ Other – 05 ____________	02	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian– 04 ☐ Other – 05 ____________
SP	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian– 04 ☐ Other – 05 ____________	03	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian– 04 ☐ Other – 05 ____________

I. Effective Date (Requesting an effective date DOES NOT GUARANTEE underwriting to be completed before the date requested.)

If Aetna approves my Application, I am requesting an effective date of the ☐ 1st or the ☐ 15th of ________________ (month).
You will be given the requested effective date if Aetna approves the Application within 30 days. This date must be no later than 90 days after the signature date (**Page 5, Section K**) of this Application. This date will be honored provided that Aetna's approval is within 30 days of the requested effective date. No requested effective date will be honored prior to or on the signature date.

Applicant's Social Security Number

Application ID Number

J. Conditions and Agreement - Please Read Before Signing Below

IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN. By filling this Application and applying for this coverage, I on behalf of myself and the dependents listed on this Application, 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 timely and accurate payment of premiums and any other contribution provided in the plan documents. If payment of premiums or any other contribution is not paid in time and accurately, your coverage will be terminated immediately. If you are terminated for nonpayment of premium, you may no longer be eligible to enroll in any of Aetna's Plans. I agree to make co-payments and any other contributions, as provided for in my plan documents, directly to providers of health care.
3. I authorize Aetna to request my and/or my dependents' (those who are applying for coverage under this Application) 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 and/or my dependents' Application. I authorize any physician, other healthcare professionals, hospitals, clinics, labs, pharmacies, pharmacy benefit managers or any other healthcare organization ("Providers") that provided treatment or any other service to me or any of my dependents applying for coverage under this Application to disclose the information required by Aetna and described above to Aetna and/or its designated agents.

   The existence of such information and documentation as described above shall be disclosed under this Application. I understand that Aetna will rely on such information to: 1) underwrite this Application for coverage, make eligibility, risk rating, policy issuance and Application determinations for all of the applicants; 2) administer coverage; and 3) conduct other insurance operations according to federal and state laws and regulations.

   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. I understand that this authorization is provided under state law and regulations. This authorization will remain valid for twenty-four (24) months. This authorization may be revoked by me at any time by completing the form entitled "Revocation of Authorization Previously Given to Aetna" available by calling the member service number on your ID card. I understand that Aetna will comply with the HIPAA Privacy Rules and that disclosure of information will be done under the rules of such Federal law.

   I understand and agree that Aetna will use any information supplied in this Application prior to the effective date of coverage in considering my Application, including any medical information.

   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.
4. I have an obligation of communicating to Aetna in writing any medical conditions which occur to myself or to any of my dependents listed in this Application after the signature of this Application and before the effective date of the coverage if approved.
5. I understand and agree that, with the exception of Aetna Rx Home Delivery, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
6. Information on agent's compensation is available from your agent or at Aetna.com.
7. 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.

K. Signature(s) Required - All applicants age 18 and over must sign and date below.

If applicant is a minor, the Application must be signed by a parent or legal guardian.

I represent that all information supplied on this form is true, complete, and correctly recorded by me. I have myself read, understand, and agree to the conditions of enrollment on this Application. I understand that the information supplied in this form will be decisive for the approval of my Application and that any misrepresentation and/or mistake in such information will be reason for cancellation/termination of the coverage for which I am applying.

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.

Once you submit this Application, you may be contacted at any time via telephone by an Aetna representative to complete your Application and the underwriting process. You will be able to confirm the identity of the person calling. Please do not answer any questions if you are not satisfied with the identity of the caller. The person calling will give you a number to confirm their identity. Please call if you have any doubts or problems with respect to the call or the process during the call.

Applicant/Parent or Legal Guardian Signature	**Today's Date**	**Applicant/Spouse** *(If applying for coverage)*	**Today's Date**
Applicant's Dependent *(Not a minor)*	**Today's Date**	**Applicant's Dependent** *(Not a minor)*	**Today's Date**

Applicant's Social Security Number

Application ID Number

L. Important Applicant Information - Please Read Carefully

1. Coverage may be declined, or a premium adjustment made, based on information provided to Aetna during the Application process. In the case of denial, you will receive a letter notifying you that your Application has not been accepted. Specific details will be kept confidential. If all members on the Application are denied coverage, the original check will be returned directly to the applicant.
2. Do ***not*** cancel other coverage presently in force until written notification is received from Aetna indicating that your Application has been approved and you and covered dependents are in receipt of your member ID card(s) providing the effective date of coverage.

PAYMENT OPTIONS

M. Easy Pay (By selecting this option you are approving the automatic withdrawal of your initial premium and all subsequent premium payments.)

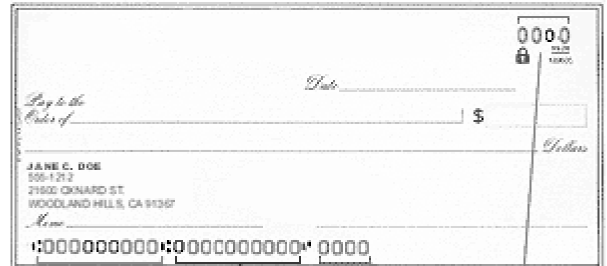
☐ **Yes**, I would like to use Easy Pay.

Checking Account Number: ____________________

Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Bank: ____________________

Name(s) on Checking Account: ____________________



☐ **No**, I do not want to use Easy Pay. Please bill me each month

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 each month. No bill will be issued**. I understand that by checking the "Yes" box above and with my Application signature on **Page 5, Section K**, I am accepting the terms of the Easy Pay Agreement.

Any rate adjustment made in accordance with the underwriting process will be automatically charged to your account. Please be advised that such rate adjustment may result in an increase of 25% to 50% of the standard rate.

NOTE: The initial premium payment will be deducted upon approval of your application. 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 (**Page 5, Section K**) even if not applying.

N. Credit Card Payment Option

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

Credit card payment is for your initial premium payment only and will be charged upon approval of your application. You will receive a bill on your next billing statement.

Any rate adjustment made in accordance with the underwriting process will be automatically charged to your account. Please be advised that such rate adjustment may result in an increase of 25% to 50% of the standard rate.

* The Verification Code can be found on the back of your credit card. This 3-digit code is usually the last three digits located in the signature panel.

O. Payment by Personal Check or Money Order

Please include a personal check or money order made payable to "Aetna" and attach to your completed Application.

P. Statement of Accountability - To be completed if the applicant cannot or has not completed the Application.

I, ____________________, personally read and completed the Individual Application for the applicant named below because: ☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English ☐ Other (explain): ____________________

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by:

____

I also translated and fully explained the "Conditions and Agreement."

Signature of Translator ***(Required)*** ____________________ Today's Date ***(Required)*** ____________

Relationship to Applicant ____________________

Applicant's Social Security Number

Application ID Number

Q. Insurance Producer Information (If applicable)

		General Agent	Insurance Broker
1.	Are you aware of any information not disclosed on this Application relating to the health, habits, or reputation of any person listed on this Application which might have a bearing on the risk? If Yes, please attach explanation.	☐ Yes ☐ No	☐ Yes ☐ No
2.	Did you see the proposed applicant at the time this Application was executed? If No, please explain:	☐ Yes ☐ No	☐ Yes ☐ No

Signature of Insurance Producer *(Required)*		**Signature of General Agent** *(Required, if applicable)*	
Date	E-mail Address info@HSAforAmerica.com	Date	E-mail Address
Name of Insurance Producer or Agency to be assigned as Broker of Record (print name) Wiley Long		Name of General Agent (print name)	
TIN of Producer or Agency to be assigned as Broker of Record 411319254		Agent TIN Number	
Street Address (Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code) 1001-A E. Harmony Rd. #519, Fort Collins, CO 80525		Street Address (Suite No./Personal Mail Box (PMB) No./City/State/ZIP Code)	
Telephone Number (800) 707-9849	Fax Number (866) 284-0082	Telephone Number ( )	Fax Number ( )

R. Aetna Sales Representative

Last Name of Sales Representative (print name)	First Name of Sales Representative (print name)

S. Instructions - *Please refer to the current Aetna Advantage Plan brochure prior to completing this Application.*

Please review these instructions.

- The Applicant must complete the Application. You are responsible to ensure that the information on the Application is correct, complete, and truthful.
- Print clearly using blue or black ink. No pencil or correction fluid, please.
- This Application must be received by Aetna's Medical Underwriting team within thirty (30) days from the signature date.
- Any misrepresentation of information on the Application may result in cancellation of coverage.
- Your insurance will become effective only if this Application is approved as applied for and the appropriate premium is enclosed.

You are ineligible for coverage if Applicant is currently pregnant (whether or not listed on the Application) or in the process of adoption; or any non-citizen Applicant has not resided in the U.S. for the last six (6) consecutive months.

Coverage is not guaranteed until approved in writing by Aetna. Do not cancel your current insurance coverage until you have been notified of approval by Aetna and your Aetna coverage is effective.

T. Effective Date

- Dates are assigned to the 1st and 15th of the month. If not selected, underwriting will assign the first available date.

To avoid delays in underwriting, please review for:

- Missing or incomplete information such as:
  - Weight AND Height
  - Date of birth
  - Physician address and phone number
- Incomplete mailing address information including city, state, and ZIP code.
- Incomplete answers to all Application sections. If a Health Question does not apply to you, the answer should be "No."
- If additional information or explanation is necessary attach extra sheets. **All attachments must be signed and dated.**

U. Payment Options

Carefully read the instructions accompanying each payment option (Page 6, Sections M, N and O).

V. Contact Information

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

Aetna Advantage Plans for Individuals, Families and the Self-Employed
Mail Stop F230
P. O. Box 61516
King of Prussia, PA 19406-0916

Fax #: 866-223-2041
www.aetna.com

Supplemental Accident Coverage

Most of our members choose to add a supplemental accident policy to their main coverage. These plans, available through *separate* insurance companies, cover 100% of the expenses related to an accident or injury after a $100 deductible.

Because accidents are the most common reason most people end up using their health insurance, having a supplemental accident plan can greatly reduce your exposure for just a small additional monthly premium.

Any amount that the accident plan pays can go toward paying qualified expenses that contribute to your deductible on your health insurance plan. So if you carry a high deductible on your health insurance plan and are hospitalized for an accident, it is likely that your accident plan would cover all but $100 of your health insurance deductible.

We offer two different level accident plans. One plan has a $5000 accident limit, the other has a $10,000 per accident limit. Monthly premiums are only $22 for the individual $5,000 plan, $35 for the family $5,000 plan, or $34 for the individual $10,000 plan and $47 for the family $10,000 plan. Payment can be made via credit card or automatic bank draft.

Please fill out *either* the $5,000 or $10,000 accident application, and submit it along with your health insurance application.

MEMBERSHIP APPLICATION

Last Name | First Name | Initial | Date of Birth

Address | Phone # | E-Mail Address

City | State | Zip Code | Social Security #

Spouse (if included) | Date of Birth

Dependent (if included) | Date of Birth

Dependent (if included) | Date of Birth

Dependent (if included) | Date of Birth

Dependent (if included) | Date of Birth

Complete ONLY If List Bill or Payroll Deduction Through Employer

Employer/Company Name | Employer/Company Phone #

$5000 Accident Shield				
	Monthly/PAC	**Quarterly/PAC**	**Semi-Annual**	**Annual**
Single	**$22.00**	**$66.00**	**$121.00**	**$220.00**
Family	**$35.00**	**$105.00**	**$192.00**	**$350.00**
$10,000 Accident Shield				
Single	**$34.00**	**$102.00**	**$187.00**	**$340.00**
Family	**$47.00**	**$141.00**	**$258.00**	**$470.00**

Add $10.00 One Time admin fee to initial payment.
Monthly & Qt direct bill add $2.50 per billing period.
Monthly direct bill requires 2 month's premium upon submission.
Group List Bill available. Ask Representative for details.

________ + ________ + **$10.00** = ________
Chosen Rate | Direct Bill | One Time Fee | Initial Payment

I hereby apply for membership with WBA and I authorize WBA and/or its authorized agent to charge my credit card for all future renewal premiums as they come due, or; I hereby request and authorize you to pay checks drawn on my account by WBA and/or its authorized agent and payable to same provided there are sufficient collected funds in said account to pay the same upon presentation, or; I authorize my employer to deduct from my earnings the required contribution, if applicable. This authorization is to remain in effect until WBA receives written notification from me revoking the authorization. I will notify WBA in writing of my wish to cancel the membership 30 days in advance.

Member Signature | Date

Payment Option

☐ **Check** ☐ **Credit Card** ☐ **Employer Sponsor**

Payment Mode

☐ **MPAC** ☐ **QPAC** ☐ **S/A** ☐ **ANN**
(PAC Attach Void Check)

☐ **Direct Mo** ☐ **Direct QT** (Add $2.50 DIRECT)

Make Check Payable to: WBA

Credit Card Information

☐ **VISA** ☐ **MC** ☐ **DISCOVER** ☐ **AMEX**

Card Number | Expiration (Mo/Yr)

Name on Credit Card

Wiley Long | 50963
Producer Name | Producer #

Mail Application To: HSA for America 1001-A East Harmony Rd. #519 - Fort Collins, CO 80525 OR FAX TO: 866-284-0082

Free Special Reports

Part of our mission is to keep our customers well-informed on additional ways that they can save money, reduce their taxes, and best insure their health and their lives. We are proud to make the following special reports available, at no cost to you.

Health Reimbursement Arrangements

A Health Reimbursement Arrangement (HRA) can enable your business to pay for your health insurance and other out-of-pocket medical expenses as a tax-free fringe benefit. This can reduce your FICA taxes, and if you are an S-corp owner it is the only way you can write off 100% of your health insurance premiums. Many small business owners use an HRA to reimburse their employees for individual health insurance premiums, saving thousands of dollars every year. Please check which report you would like, and we will send it right away:

☐ **Section 105 HRA Plans for the Self Employed**

☐ **105 HRA Plans for S Corps**

☐ **105 HRA Plans for Small Groups**

Term Life Insurance

Term Life Insurance rates are lower than they have ever been. This report includes a worksheet to help you determine how much life insurance you should carry, and explains clearly what your options are and how to find the best rates. If you would like this report, please check the box below and we will send it right away.

☐ **The Consumer's Guide to Life Insurance**

Help HSA for America Spread the Word about Consumer Driven Healthcare

As an HSA owner, you are allowed to make deposits into a special account that has the most tax-favored status of any investment account, including Roths, 401ks, SEPs, IRAs, or anything else*. You have lower taxes, and lower health insurance premiums.

In the next twelve months we are predicting an additional 5 million people will obtain HSA plans. This many people paying for their own minor medical bills will force medical providers to finally compete for our business. The power of the free market will cause prices to drop, and convenience and quality will rise.

So if you have friends, family, or business associates who pay for their own health insurance and are not yet aware of HSA plans, you can let them know right now.

Give us their contact information and we'll send them a free copy of our special report, "**The Complete Consumer's Guide to HSAs**," along with a free **Customized HSA Quote**, analyzing the best available plans for their needs and in their zip code. Oh, and if they sign up for a health insurance plan, we'll send you a $50 gift certificate to Outback Steaks or Starbucks…

Name: ____
Address: ____
Cty: ____
State: ________________________ **Zip:** ___________
Email: ____
Phone: ____

Name: ____
Address: ____
Cty: ____
State: ________________________ **Zip:** ___________
Email: ____
Phone: ____

Name: ____
Address: ____
Cty: ____
State: ________________________ **Zip:** ___________
Email: ____
Phone: ____

*HSAs are said to have a triple tax advantage because you get a deduction when you make a deposit, the money grows tax-deferred, and your withdrawals are tax-free if used to pay for qualified medical expenses.