Aetna® Family Health Statement

Check One: ☐ New Group
☐ New Employee Add
☐ Existing Employee Change

A. Employer Information – *To be completed by Employer*

Employer Name (Please Print)		Policy Number	
Employer Street Address (P.O. Box not acceptable)	City	State	Zip
Applicant's Occupation	Hours Worked/Week	Full Time Hire Date (MM/DD/YYYY)	

B. Decline Coverage – *Must be completed by the employee.*

☐ I **Decline** to enroll for Health coverage due to the existence of other group health coverage for:

☐ Myself ☐ Spouse ☐ Dependent Child(ren)

If I and/or my dependents decline coverage and desire to participate in the plan at a later date, **I may** have to submit evidence of insurability satisfactory to the insurance company.

Employee Signature	Date (MM/DD/YYYY)

C. Request Coverage – *Answer ALL questions if additional space is needed, attach separate sheet. Complete for all family members applying for coverage*

Name (First, Initial, Last)	**Height** (ft., in.)	**Weight** (lbs.)	**Birthdate** (MM/DD/YYYY)	**Sex** M/F	**Full Time Student** Yes/No – If Yes, Name School
Employee					☐ No ☐ Yes -
Spouse					☐ No ☐ Yes -
					☐ No ☐ Yes -
					☐ No ☐ Yes -
					☐ No ☐ Yes -
					☐ No ☐ Yes -

Employee Social Security Number		Employee Marital Status ☐ Single ☐ Married		
Employee Street Address (P.O. Box not acceptable)		City	State	Zip
Employee Home Telephone ( )	Employee Work Telephone ( )	Where would you prefer to be called during the day? ☐ Home ☐ Work		

I hereby represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief and understand that the said answers and statements form the basis upon which insurance will be made effective. I understand that omissions, misrepresentations, or misstatements about medical history could result in the denial of an otherwise valid claim and rescission, voiding, or reformation of insurance.

Employee Signature	Date (MM/DD/YYYY)
Spouse Signature	Date (MM/DD/YYYY)

Other side must be completed.

Employer Name (Please Print)

D. Employee Eligibility

- Are you now actively at work full time (30+ hrs/week)? ☐ Yes ☐ No
- Does your spouse have medical coverage elsewhere? ☐ Yes ☐ No
- Is any person to be insured currently covered under COBRA? ☐ Yes ☐ No
- Is any person to be insured enrolled in Medicare? ☐ Yes ☐ No

If Yes, who: _____ ☐ Medicare A ☐ Medicare B

E. Health Information – To request coverage answer ALL questions. Details may be submitted via sealed envelope marked "confidential" for "Yes" answers, details must be provided. *If illness is unlisted, provide details in the row marked "other".*

1. Are you, your spouse, or any dependent to be insured, currently disabled or unable to perform their normal activities? ☐ Yes ☐ No
   Who/Why: _____
2. Have you, or any dependent, been hospitalized, or been advised to be hospitalized within the past 5 years for any reason? ☐ Yes ☐ No
   Who/Why: _____
3. Have you, or any dependent, had surgery, or been advised to have surgery within the past 5 years for any reason? ☐ Yes ☐ No
   Who/Why: _____
4. Are you, or any dependents to be covered, currently pregnant? ☐ Yes ☐ No
   Who/Expected Delivery Date: _____
5. Is this pregnancy the result of infertility treatment? ☐ Yes ☐ No
   Please explain: _____
6. Are you or any dependents to be covered, currently taking any medication? ☐ Yes ☐ No
   Who/Why: _____
   Medication: _____
7. Have you, or any dependent, had medical expenses in excess of $5,000.00 in the last 12 months? ☐ Yes ☐ No
   Who/Why: _____
8. Have you, or any dependent ever had, or has a Medical Professional told, counseled, or treated, you or any dependent, for any of the following:

	Yes	No	Person Affected	Diagnosis & Date Diagnosed	Treatment and/or Medication	Degree of Recovery	Name, Address & Telephone Number of Physician and/or Hospital
a) Chest Pain, Heart Attack, or other heart condition	☐	☐					
b) Condition/Disease of the circulatory system (i.e. blood vessels, phlebitis, leg ulcers)	☐	☐					
c. Cancer, tumor, or lymph node enlargement (indicate type of cancer and location)	☐	☐					
d. Acquired Immuno Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)	☐	☐					
e. High Blood Pressure (if yes, provide most recent reading)	☐	☐					
f. Diabetes or disorder of endocrine system or glands (indicate if insulin dependent)	☐	☐					
g. Alcohol or drug use, abuse, and/or dependency	☐	☐					
h. Disease of the kidney, bladder or urinary tract	☐	☐					
i. Crohns, Colitis, diseases of stomach, intestine, esophagus or gallbladder	☐	☐					

Employer Name (Please Print)

E. Health Information (Continued)

j. Disorder of the liver or pancreas	☐	☐					
k. Disorder of the lungs or respiratory system	☐	☐					
l. Organ Transplants (if yes, include type and date)	☐	☐					
m. Neurologic problems--disorder of the brain, seizures, epilepsy, central nervous system--stroke or paralysis	☐	☐					
n. Nervous, mental, depression, stress or anxiety related disorder, eating disorder	☐	☐					
o. Disorder of the blood (including anemia)	☐	☐					
p. Lupus or Arthritis (if yes, indicate type and severity of disability)	☐	☐					
q. Congenital anomalies or disorders	☐	☐					
r. Other (any disease/condition not listed above)	☐	☐					