HIPAA* Coverage Form – California

*(Health Insurance Portability and Accountability Act)

Please mail this form to:
Attn: Unit 212
Aetna
PO Box 730
Blue Bell, PA 19422

Demographic Information

Last Name, First Name, M.I.				
Home Address (P.O. Box not acceptable)				
City			State	Zip
Billing Address (If different than above address)				
City		State	Zip	**County *(Required)***
Gender ☐ Male ☐ Female	Date of Birth	Social Security Number		Home Telephone Number

Dependent Information

1. Last Name, First Name, M.I.			
Relationship ☐ Spouse ☐ Child	Gender ☐ Male ☐ Female	Date of Birth	Social Security Number
2. Last Name, First Name, M.I.			
Relationship ☐ Spouse ☐ Child	Gender ☐ Male ☐ Female	Date of Birth	Social Security Number
3. Last Name, First Name, M.I.			
Relationship ☐ Spouse ☐ Child	Gender ☐ Male ☐ Female	Date of Birth	Social Security Number

HIPAA Eligibility

1. Have you had at least18 months of prior creditable coverage most recently under an Employer sponsored group health plan, governmental plan, or church plan or an individual health plan purchased in **California** that terminated due to the insurer becoming insolvent or discontinuing coverage in this State, or you no longer live in the service area in the State of **California** of the insurer that provides coverage in this State and this coverage ended within the last 63 days of the end date of your previous plan for a reason other than fraud or non-payment of premium? ☐ Yes ☐ No
   If **Yes,** please attach the Certificate of Coverage provided by your former employer or carrier OR letter from your employer giving us the start and end date of coverage.
   Name of insurance carriers: _____ Telephone Number (____) _____
   If **No,** you are **not** eligible for this guarantee issue plan.
2. Were you eligible for COBRA? ..... ☐ Yes ☐ No
   If **Yes,** Date coverage started (Mo/Day/Year): _____
   Date coverage ended (Mo/Day/Year): _____
   If **No**, please explain: _____
3. Are you currently covered by or eligible for Medicaid, Medicare or any employer-sponsored Health insurance benefits or do you have other health coverage? ..... ☐ Yes ☐ No
   If **Yes,** you are **not** eligible for this coverage.
4. Were you cancelled for fraud or non-payment of premium? ..... ☐ Yes ☐ No
   If Yes, you are not eligible for this coverage.
5. If you applied for the Aetna Advantage Plans for Individuals, Families and the Self-Employed, the following requirements must be met:
   a. You must have applied for the Aetna Advantage Plans for Individuals, Families and the Self-Employed within 63 days of the end date of your previous plan.
   b. You must have inquired about enrollment as a HIPAA eligible individual within 30 days of the declination for enrollment in the Aetna Advantage Plans OR within 63 days of the previous plan.

Effective Date

Aetna may assign an effective date of the 1st or the 15th of the month following the approval date. Effective date must be within 63 days of the prior coverage termination date. Aetna may allow a retroactive effective date of the 1st or 15th of the month following the prior coverage termination date.

Conditions and Agreement
It is important that you read and understand the following before you sign.

Agreement

I, the undersigned, agree to the following:

1. No coverage will come into effect until Aetna notifies me in writing.
2. Coverage and benefits once they come to 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 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.
4. 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.

Authorization

I authorize any physician, other healthcare professional, hospital, pharmacy, pharmacy benefit manager or any other healthcare organizations ("Providers") to give Aetna or its agents information concerning the medical history, prescription history, services or treatment provided to the applicant listed on this HIPAA coverage form, including those involving mental health, substance abuse and AIDS/ARC. I further authorize Aetna to use such information and disclose 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 understand that this authorization is provided under state law, and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act ("HIPAA"). This authorization will remain valid for the term of the coverage and if so long thereafter as allowed by law. 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 HIPAA coverage form prior to the effective date in considering my application. 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.

Signature Required

I represent that all information supplied in this form is true and correctly recorded by me. I have myself read, understand and agree to the Conditions and Agreement. I understand that any misrepresentation and/or mistake in such information supplied, will be reason for cancellation/termination of coverage.

I UNDERSTAND THAT IF MY SIGNATURE/DATE DO NOT APPEAR AND/OR ARE NOT CURRENT AND/OR MY ANSWERS ARE INCOMPLETE, COVERAGE MAY BE AFFECTED.

Signature	Date

Aetna Sales Agent

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

Agent's Signature	Date

PAYMENT OPTIONS

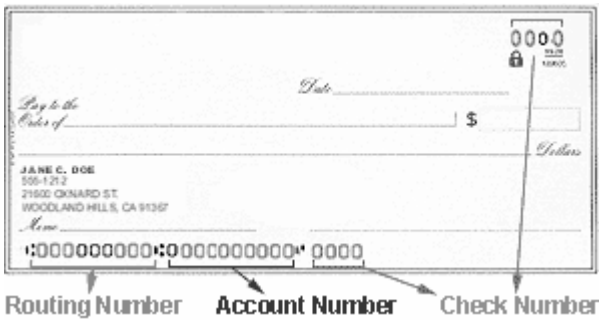
Easy Pay (Electronic Funds Transfer –EFT)

☐ Yes, I would like to use Easy Pay.

Checking Account Number: _____ Routing Number | | | | | | | | | |

Name of Bank: _____

Names on Checking Account: _____



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

Terms of Agreement: My account(s) at the institution named has sufficient funds to pays all debts 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. No bill will be issued.** I understand that by checking the "Yes" box above and my signature on page 2 I am accepting the terms of the Easy Pay Agreement.

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.

Credit Card Payment Option

Credit Card Type

☐ VISA ☐ MasterCard

Cardholder's Name (exactly as it appears on the card)

Account Number

				–					–					–				

Card Expiration Date

Payment by Personal Check or Money Order

Please include a personal check or money order made payable to "Aetna" and attach to this form.

Statement of Accountability – to be completed if the individual to be covered cannot or has not completed this HIPAA Coverage Form.

I, _____, personally read and completed the HIPAA Coverage Form for the individual named below because:

☐ Individual does not read English ☐ Individual does not speak English ☐ Individual 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 information disclosed by: _____

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

Signature of Translator ***(Required)***: _____ Today's Date ***(Required)***: _____

Relationship to Individual _____

DMHC Written Notice of Availability of Language Assistance

HMO and DMO-based plans - **IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-877-287-0117.

Planes basados en DMO y HMO - **IMPORTANTE:** ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-877-287-0117. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-877-287-0117. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-877-287-0117 與我們聯絡。欲取得其他協助，請致電1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-877-287-0117 . Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-877-287-0117번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-877-287-0117. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-877-287-0117 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-877-287-0117. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-877-287-0117までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجاني مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-877-287-0117 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-877-287-0117 'ਤ ਸਾਨ ਫ਼ਨ ਕਰੋ। ਵਧੇਰ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

េសវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមាន បង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-877-287-0117 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-877-287-0117 . للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357.Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-877-287-0117. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

CDI Notice of Language Assistance-Trad