

Wait!

**Please call before
attempting to complete your application!**

Avoid headaches and delays by allowing our office to assist you. We can help you complete your application and answer any questions you may have. You'll be surprised at how simple completing an application can be.

1 800 721-2618

(6:30 a.m. to 6:30 p.m. PST. Monday through Friday)

Please mail your application to:

Health One Insurance Agency
1344 Disc Dr. #210
Sparks, NV 89436
Attn: APDT

Or you may fax your application to:

800 905-6750

Applicant's Social Security Number
 | | | | | | | |

Application ID Number
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F. 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 H. Missing information may delay processing this Application.

In the past ten (10) years, has any person listed on this Application consulted a health care provider, received treatment (including prescription medications) or been hospitalized for any of the following conditions or diseases?

F1.	Eyes, Ears, Nose and Throat Conditions/Disorders: <i>Eyes/sight:</i> glaucoma, cataracts, crossed eyes, detached retina, corneal transplant, infections; <i>Ears/Hearing:</i> loss of hearing, deafness, infections, eustachian tube dysfunction; <i>Nose/breathing:</i> deviated septum, polyps, adenoiditis, sinusitis; <i>Throat/Swallowing:</i> tonsillitis, strep throat, excessive snoring or sleep apnea, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F2.	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, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F3.	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, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F4.	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, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F5.	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, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F6.	Urinary Conditions/Disorders: Bladder infections, kidney infections, stones, blood in urine, stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F7.	Heart and Circulatory Conditions/Disorders: Anemia, bleeding/clotting disorders, Hemophilia, 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, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F8.	Metabolic and Endocrine Conditions/Disorders: Diabetes, adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis, thyroid disorders, AIDS/ARC, any immune disorder (not including the result for the HIV test)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F9.	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), etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F10.	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, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F11.	Female Reproductive Conditions/Disorders:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	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, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: Applicant Name _____ Reason _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c) Has any female had an abnormal PAP Smear? If Yes, provide details in H1 .	<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
F12.	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, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F13.	Cancer/Tumors: Cysts, tumors or abnormal growths, Hodgkin's disease, leukemia or any other cancer or malignancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F14.	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, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F15.	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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

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G. Health Related Questions (Include information for all persons enrolling for coverage.)

Answer all questions & provide complete details to all "Yes" answers on Page 3, Section H. Missing information may delay processing this Application.		
G1.	Is any male applicant expecting a child or in the process of adoption or surrogacy with anyone whether or not that person is enrolling for coverage on this Application? If Yes, provide applicant name below. Applicant Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
G2.	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: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
G3.	Has any applicant ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal or IV drugs? Applicant Name: _____ Type of Drug/Substance: _____ Date Discontinued: _____ Applicant Name: _____ Type of Drug/Substance: _____ Date Discontinued: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
G4.	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 <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month Applicant Name: _____ Type: _____ Amount: _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No
G5.	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 _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
G6.	Has any applicant had any abnormal lab results, X-rays, MRI or other diagnostic test results or physical exam results?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G7.	Has any applicant been medically advised to undergo further medical testing, treatment or surgery which has not yet been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G8.	Has any applicant been a patient in an outpatient clinic, hospital, surgical center, treatment center or other medical facility in the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G9.	Has any applicant seen any health care provider for any condition, signs or symptoms which have not yet been diagnosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G10.	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 _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
G11.	Has any applicant taken prescription medications or been advised to take prescription medications in the last 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G12.	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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G13.	Is any applicant a candidate for, or a recipient of, an organ, bone marrow or stem cell transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G14.	Is any applicant currently on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

H. Detailed Health Information

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

2. List all prescription medications and or doctor's 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.

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H. 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(s)

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.

I. 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	<input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____
APP	<input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	02	<input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____
SP	<input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	03	<input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latino - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____

J. Statement of Enrollment 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.

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K. 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 enrolling 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 claims and determine or fulfill responsibility for coverage and provisions of benefits; 3) administer coverage; and 4) 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 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 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.

L. 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 enrollment and that any misrepresentation and/or mistake in such information will be reason for cancellation/termination of the coverage for which I am enrolling. I UNDERSTAND THAT IF MY SIGNATURE/DATE DO NOT APPEAR AND/OR ARE NOT CURRENT AND/OR MY ANSWERS ARE INCOMPLETE, my enrollment will be declined.

Once you submit this Application you may be contacted at any time via telephone by an Aetna representative to complete your enrollment 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 enrolling 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								

M. Important Applicant Information Please Read Carefully

- 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.
- 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

N. Easy Pay (Electronic Fund Transfer - EFT)

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. No bill will be issued.** I understand that by checking the "Yes" box above and with my Application signature on Page 5 (Section L) 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: 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 L) even if not applying.

O. 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. 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.

P. 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.

Q. 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 _____

X

X

service@justhealthplans.com

Just Healthplans Inc , Gary E. Jackson

1344 Disc Dr. #210 Sparks, NV 89436

800 721-2618

800 905-6750

U. Instructions: *Please refer to the current Aetna Advantage Plan brochure prior to completing this enrollment form.*

Please review these instructions.

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

You are ineligible for coverage if Subscriber is currently pregnant (whether or not listed on the enrollment form) or in the process of adoption; or any non-citizen Subscriber 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.

V. 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 telephone number
- Incomplete mailing address information including city, state, and ZIP code.
- Incomplete answers to all enrollment form 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.**
- If the Subscriber chooses a PPO product, complete the Joinder agreement section.

W. Payment Options

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

X. Contact Information

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

Aetna Advantage Plans for Individuals & Families

Mail Stop F230

P. O. Box 61516

King of Prussia, PA 19406-0916

Fax #: 866-223-2041

www.aetna.com