



# Aetna Individual Advantage (SM) for Individuals and Families

## Instructions:

- Enrollment form must be completed by the subscriber in blue or black ink. **Please PRINT clearly. (A photocopy of this enrollment form will not be accepted.)**
- Enrollment form must be completed in its entirety and one (1) form of payment selected or processing time will be delayed.
- Signature and date is required.

## Send completed enrollment form to:

Aetna Advantage Dental Plans, U22N  
P.O. Box 730  
Blue Bell, PA 19422

## Fax Form to:

Individual billing and Enrollment 1-860-975-1620

## A. Subscriber Information

Last Name (Last, First, Middle Initial)		First Name		Middle Initial	
Address		City		State	ZIP Code
Home Telephone Number (Include Area Code)		Cell Phone Number (Include Area Code)		E-Mail Address (Optional)	

## B. Election of Dental Coverage

- Aetna Individual Advantage Dental PPO Plan       Aetna Individual Advantage Dental PPO Plus Plan

## C. Individuals Covered (Complete this section for all persons enrolling for dental coverage, including yourself, spouse and/or family member(s). You may enroll any or all eligible family members.)

Family Code*	Last Name	First Name	M.I.	Social Security Number	Date of Birth (MM/DD/YYYY)	Sex (M/F)
APP						
SP						
DEP 1						
DEP 2						
DEP 3						

## D. Effective Date

If Aetna approves my enrollment form, I am requesting an effective date beginning the 1<sup>st</sup> of the \_\_\_\_\_ (month).

## E. Signature

Applicant's Signature	Date
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## PAYMENT OPTIONS

### F. 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.



Routing Number      Account Number      Check Number

**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 enrollment form signature on **Page 1, Section E**, 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.**

**NOTE: The initial premium payment will be deducted upon approval of your enrollment form.** 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 1, Section E**) even if not applying.

**PAYMENT OPTIONS (continued)**

**G. Credit Card Payment Option**

Credit Card Type <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard		Cardholder's Name (exactly as it appears on the card)		
Account Number □ □ □ □ - □ □ □ □ - □ □ □ □ □ □ □ □		Card Expiration Date	Card Verification Code* □ □ □	
<b>Credit card payment is for your initial premium payment only and will be charged upon approval of your enrollment form. You will receive a bill on your next billing statement.</b>				
Any rate adjustment made in accordance with the underwriting process will be automatically charged to your account.				
*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.				

**H. Payment by Personal Check or Money Order**

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

**I. Insurance Producer Information (Please complete the information below in full)**

1. Are you aware of any information not disclosed on this enrollment form relating to the health, habits or reputation of any person listed on this enrollment form which might have a bearing on the risk? If "Yes," please attach explanation.			<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Did you see the proposed applicant at the time this application was executed? If you answered "No" to either question above, please explain:			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Signature of Insurance Broker (Required if sold by an agent/broker)		Name of General Agent (print name)		
Date	E-mail Address	E-mail Address		
Name of Insurance Broker (print name)		General Agent TIN Number		
TIN of Broker or Agency		Address (Street, Suite #, POB, City, State, ZIP Code)		
Address (Street, Suite #, POB, City, State, ZIP Code)		Telephone Number (    )		
Telephone Number (    )	Fax Number (    )	Fax Number (    )		

**J. Aetna Sales Representative (if applicable)**

Last Name of Sales Representative (print name)	First Name of Sales Representative (print name)
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**K. Authorization**

I have read the information contain in this application and choose to enroll. I understand that my enrollment is subject to receipt of payment and verification of funds. Eligibility will begin on the first day of the month following receipt of the enrollment form. I understand that the Electronic Funds Transfer (EFT) for the monthly premium payment will be automatically deducted from my bank account.

I hereby certify that the information contained in this application is true and complete.

Applicant's Signature	Date
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