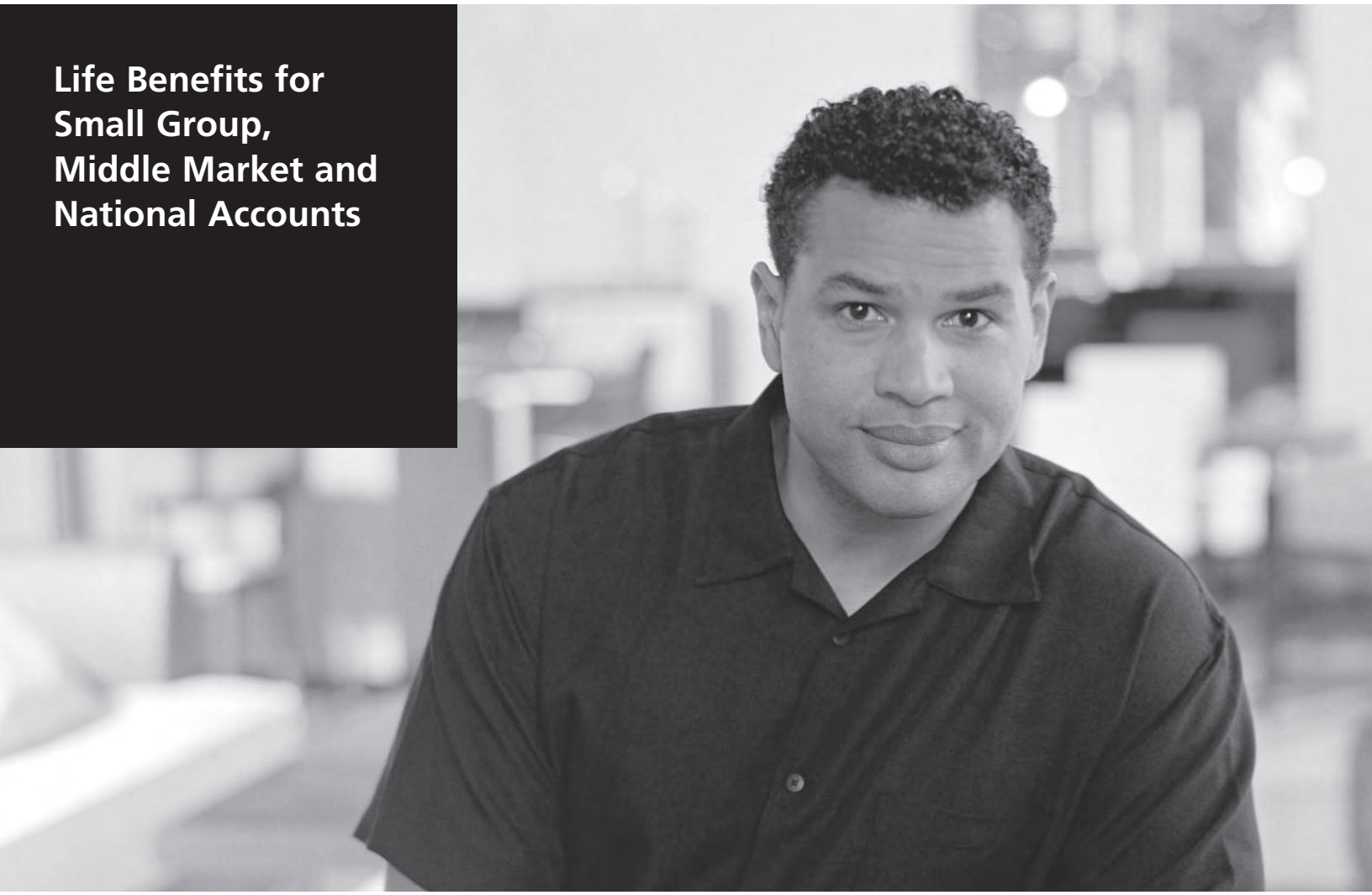
Life Administrative Handbook

Aetna Life Coverage

Life Benefits for Small Group, Middle Market and National Accounts



We want you to know®

Aetna®

26.20.001.1 (05/08)

Dear Plan Sponsor:

Welcome! We're pleased you've chosen Aetna and look forward to working with you.

At Aetna,[‡] we want you to know. By providing information and tools that are accessible, simple and clear, we're committed to giving you what you need to make better decisions for your business and your people.

To that end, this handbook provides a summary of the administrative information you'll need to help you administer your Aetna plan. It is important that you understand the provisions of the plan, particularly the need to submit timely and accurate data and other information described in the handbook. The Customer Service Information sections, immediately following this letter, contain phone numbers and addresses for the Aetna departments you will need to contact.

As you read through this handbook, you may come across terms or references that do not apply to the plan of benefits you have selected. The actual terms of your group plan are detailed in the plan documents we have already provided to you.

Thank you for choosing Aetna. It's our privilege to serve you.

Sincerely,

Aetna

[‡]Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies (Aetna).

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Customer Service Information

In this chapter and throughout this handbook, we will continuously make reference to, and refer you back to, the provisions of your policy, in order for you to determine which benefits and limitations apply to you. Policy is defined as the legal document or contract issued by the insurance company (insurer) to the policyholder that sets forth the terms and conditions of the insurance.

This chapter provides information and instructions for contacting Aetna when you have a question or a problem with your Group Policy. It also provides instructions and guidance for ordering additional forms when needed.

Important: When contacting Aetna, please be prepared to give the person assisting you certain information specific to your Group Policy. For example, be prepared to provide your policy's control, suffix and account number whenever you make a call. If you are calling in regard to an employee matter, be prepared to provide the employee's Social Security number. Having this information readily available will help avoid delays in customer service.

Inquiries

For questions or problems concerning your billing statement (for example, Summary Statement or List Bill Statement) or any other aspect of the administration, or for which a specific address or phone number has not been provided, contact the following in the order of presentation:

- Your servicing Aetna claims office (if it involves a claims issue).
- Your Aetna representative.*
- The Customer Service Unit or contact name as it appears on your billing statement.**
- Or if you prefer, you can write to the Aetna Plan Sponsor Services location that services your Group Policy.

Aetna – Plan Sponsor Services

Mailing Address: _____

_____

_____

_____

Enrollment/Changes: Phone: _____

Fax: _____

Control: _____ Suffix: _____ Account: _____

Aetna – Marketing

Marketing Office: _____

_____

_____

_____

_____

Service Representative

Phone: _____

Fax: _____

*Contact your Aetna service representative when you have a question regarding renewing your group plan. Otherwise, direct **all calls, except for claims or benefits questions**, to the Customer Service Unit at the toll-free number listed on your billing statement.

Please note that this number is for your group benefits administrator or an individual who has the authority to act on behalf of your company. **The number is not to be released to employees. Employee claims and benefits questions should be directed to the toll-free number shown on the employee's ID card.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Customer Service Information (*continued*)

Life Insurance Service Center

Life Insurance PW and ABD claims
Please send all Group Disability forms (for example, Premium Waiver and Death Benefit Only/Aetna Investigates Disability) and any proof of disability to:

Aetna Life Insurance Company
P.O. Box 14548
Lexington, KY 40512-4548

Life and AD&PL claims
Please send all Proof of Death forms and Accidental Death and Personal Loss claim forms to:

Aetna Life Insurance Company
P.O. Box 14549
Lexington, KY 40512-4549

If you have questions concerning the filing of a life or dismemberment claim or simply need to check on the status of a claim, call the Life Insurance Service Center or fax us at the following toll-free numbers:

1-800-523-5065 (phone)
1-800-238-6239 (fax)

Evidence of Insurability

Please send all Evidence of Insurability Statements to:

Aetna Life Insurance Company
Medical Underwriting Department
P.O. Box 83641
Lincoln, NE 68501-3641

OR

Fax to: 1-800-792-9710

If you have questions, call us toll-free at 1-800-660-9913.

Forms and supplies

The necessary forms will be provided to you by your Aetna representative.

When you need additional forms required for the administration of your Group Policy, order forms as follows.

Enrollment forms

To order additional enrollment forms, please call your Aetna representative.

All forms, other than enrollment forms

If the form number is GR-50000 to GR-59999, please order additional copies from your Aetna representative.

If the form number is GR-60000 to GR-69000, please order additional copies using the Customer Request form and the special return envelope. A copy is shown on the following pages. When using this form, be sure to include your Group Policy's control number, along with a copy of the form being requested.

If the form number begins with the letters "GC," please order additional copies and envelopes through the claim office or your Aetna representative using form GC-634. When using this form, be sure to include your Group Policy's control number, along with a copy of the form being requested.

Contact your Aetna representative when you have a question related to the renewal of your Group Policy. Otherwise, direct all calls, except for claims or benefits questions, to the Customer Service Unit at the number listed on your billing statement.

Please note that this number is for the group benefits administrator or someone who has the authority to act on behalf of the policyholder. This number is not for release to the policyholder's covered employees.

Life Insurance and Accidental Death & Personal Loss Insurance

This handbook covers Aetna's Group Term Life Insurance and Accidental Death & Personal Loss (AD&PL) Insurance and the different benefit features that may be included under your Aetna Group Policy.

Unlike health insurance, where much of the claims work is handled by the provider of services, Life Insurance and AD&PL Insurance requires much more detail and attention from you, as the policyholder, in order to ensure accurate and timely benefits changes and claims submissions. As such, this handbook provides information on the different forms Aetna will require to support a benefit change or claim submission and gives details and instructions for completing those forms.

This handbook will also help you in administering your Group Policy.

This handbook should be used as a reference guide and does not replace or supersede the benefits described in your Group Policy. Please refer to your Group Policy for Policy-specific information.

If you have questions regarding any of the information covered in this chapter, please call Aetna's Life Insurance Service Center at 1-800-523-5065.

Enrollment

For most companies, enrollment and benefit change activity constitutes the biggest piece of the administration process. As such, Aetna recommends that you familiarize yourself with these sections. Pay particular attention to the information that must be included on an Enrollment/Change Request form in order to prevent potential claim problems caused by delayed enrollment or missing information.

What is an annual benefits election period?

The annual benefits election period is the time of year when your employees can evaluate their benefit needs and select the coverage that best meets their needs for the following year.

What are the enrollment requirements for contributory coverage/noncontributory coverage?

For contributory coverage:
Aetna requires that at least 20 percent of all eligible employees must enroll for Life Insurance and at least 20 percent of all eligible employees must enroll for Accidental Death and Personal Loss coverage.

For noncontributory coverage:
Aetna requires that **100 percent of all eligible employees be enrolled for all noncontributory coverages**. If dependent coverage is included under the policy and employees do not contribute toward the cost of **dependents' benefits, dependent coverage cannot be refused.**

Aetna reserves the right to audit payroll records to ensure that participation requirements are being met. If the participation requirements are not met, Aetna has the right to cancel your Group Policy by giving you advance written notice. If your Group Policy is cancelled, your employees may be eligible to convert their coverage to a policy of individual insurance. Please refer to the Life Conversion chapter of this handbook for details concerning conversion and to your Group Policy for the specific terms regarding Aetna's rights to cancel coverage.

Probationary period

As the employer, you have the discretion to decide whether or how long newly hired employees (or if you choose to, existing employees) must wait in order to be eligible for coverage under the active group coverage. This is called the probationary period. If employees are required to serve a probationary period, it must be applied equally to all employees in that class.

If you select a probationary period, the eligibility date under the Group Policy is the day after the employee finishes serving his/her probationary period. In order to be eligible for coverage, the employee must sign and return the Enrollment/Change Request form within 31 days of the eligibility date. Otherwise, the employee will be treated as a "Late Enrollee." If the employee is a Late Enrollee, coverage will be subject to the requirements outlined in the Late Enrollees section that follows.

If the employee elects coverage before the end of his/her probationary period, coverage will take effect on the eligibility date. Otherwise, coverage will take effect on the date the employee returns the signed Enrollment/Change Request form, provided it is within 31 days of the eligibility date.

Examples:

1. ABC Company imposes a three-month probationary period. Jim Smith is hired on January 1, and fills out an Enrollment/Change Request form for the group Life coverage immediately. Since Jim must first serve his probationary period, his eligibility date under the Group Policy is April 1. Jim's coverage under the Group Policy will not become effective until April 1.
2. ABC Company imposes a three-month probationary period. Jim Smith is hired on January 1, making his eligibility date April 1. On April 24, he gives his signed Enrollment/Change Request form to you. Jim can be covered, since he signed and returned his enrollment form to you within 31 days of his eligibility date. His coverage becomes effective on April 24.
3. ABC Company imposes a three-month probationary period. Jim Smith is hired on January 1, making his

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Enrollment (*continued*)

eligibility date April 1. On May 19, he gives his signed Enrollment/Change Request form to you. Since Jim did not enroll within 31 days of his eligibility date, he is subject to the Late Enrollee requirements outlined in the effective date of coverage section of his Group Policy.

Active-at-Work rule

If an employee is away from work because of illness or injury on the date group Life coverage would otherwise take effect, such coverage will not take effect until the employee returns to work for one full day. Dependent coverage will usually take effect when the employee's coverage takes effect if, by then, the employee has enrolled for dependent coverage. New dependents not enrolled within 31 days of the dependent's eligibility date will be subject to Late Enrollee requirements.

When are employees considered Late Enrollees?

When employees do not elect coverage within the 31-day period from their eligibility date, they and their dependents are considered Late Enrollees.

To avoid being considered a Late Enrollee, the Enrollment/Change Request form must be:

- Signed by the employee no later than 31 days after the annual benefits election date or hire date.

Unless this condition is met, the enrollee will be considered late and will need to submit Evidence of Insurability. Please see the Evidence of Insurability chapter for more information. In addition, some policies do not allow for late enrollment and require a Late Enrollee to wait until the next annual benefits election period to enroll for coverage. Please refer to the effective date of coverage section of your Group Policy for specifics.

Example:
The "annual benefits election date" is November 1. To qualify:

- The Enrollment/Change Request form must be signed by the employee (or made by phone*) on or before December 1.
- The Enrollment/Change Request form must be received by Aetna on or before January 1.
- If the request is received January 2 or later, the employee is considered a Late Enrollee and enrollment will not be accepted.

If the state mandates an annual benefits election period that is greater than 31 days, the mandated enrollment period will be used for the initial enrollment of a member.

Duplicate coverage

Your Group Policy may not allow individuals to be covered both as an employee and as a dependent. In addition, no person may be covered as a dependent of more than one employee, except where required by state law. Your Aetna representative can provide you with more specific information about what your Group Policy provides with respect to duplicate coverage. You may also refer to the eligibility section of your Group Policy's Summary of Coverage.

How do I enroll new employees?

Enrollment can be made an integral part of the hiring process for new employees. By providing enrollment materials and benefits literature to your employees when they first begin work, you are allowing them to make informed benefits decisions. This also helps prevent potential claims problems caused by delayed enrollment or missing information.

Note: The Enrollment/Change Request form is used for adding new employees, terminating employees and making changes to existing elections. A sample form is shown later in this chapter.

If you choose to make enrollment a part of the hiring process, you should provide the following to new hires:

1. **Enrollment/Change Request form –** Many states have laws that govern the information that may be collected on an enrollment form. As such, it may be necessary to use more than one enrollment form for your workforce. All enrollment forms must be approved by each Department of Insurance prior to use. Therefore, in many cases custom employer enrollment forms cannot be accepted by Aetna. The use of custom enrollment forms for full-risk and self-insured business requires advance approval of the forms by Aetna

*In this example, if the request is received by Aetna by phone during December, the caller must confirm on a recorded phone call that the member did sign and return the form to the employer by December 1.

and, when required by the state in which the business is written, state filing of the proposed enrollment forms with the appropriate regulatory authority. Your Aetna service representative will ensure you are given the appropriate enrollment forms. A sample with instructions is shown later in this chapter.

2. **Booklet/Certificate –** Your Group Policy's Booklet/Certificate contains a detailed description of the Policy's benefits and limitations. If you offer a choice of more than one policy of benefits, employees should be given a copy of each Booklet/Certificate.
3. **Privacy Notice –** The Privacy Notice describes certain aspects of Aetna's insurance privacy policy. This privacy policy applies to individuals who are covered under an Aetna group insurance policy. For your convenience in providing this policy to your employees, a copy of Aetna's privacy policy appears on page 10.

How do I complete an Enrollment/Change Request form?

The Enrollment/Change Request form is used to enroll new subscribers process changes in family status such as the birth of a child or marriage or change Policy coverage.

Enrollment/Change Request forms vary according to state and the Policy selected. Your Aetna representative can provide you with these correct forms.

Most Enrollment/Change Request forms have three parts:
1. Aetna copy.
2. Employee copy.
3. Employer copy.

It is very important that we receive the required information detailed below on each Enrollment/Change Request form. As the employer, you are responsible for making sure all Enrollment/Change Request forms are properly completed by your employees before calling, mailing or faxing them to us. If any of the required information is missing, it may lead to a delay in enrollment or potential claims problems.

If you have any questions, call your Aetna representative, whose phone number is on your billing statement.

Explaining the Enrollment/ Change Request form

A sample of the Life and AD&PL/AD&PL Enrollment/Change Request form appears at the end of this chapter. The following explains what information is needed in each section of the Enrollment/Change Request form.

Effective date
This is the date the employee's coverage will take effect. For example, if an employee starts work on February 1 and has to serve a two-month probationary period, the effective date should be shown as April 1.

Employee hire date
Fill in the date the employee was hired.

Employee Social Security number
Fill in the employee's SSN. This is necessary to process any future transactions, including claim payment.

Section A: Transaction information
1. Enrollment
Indicate if the Enrollee is a New Enrollee or Rehire.

Requested employee coverage
Check the box(es) for which the employee elects coverage.

Requested dependent coverage
If your Policy has dependent coverage, and the employee elects dependent coverage, check the box(es) that apply for dependent coverage.

2. Termination
Check this box if the transaction being requested is to terminate or cancel coverage for an employee. Please see the "More Information on Terminations or Cancellations" section in this chapter for further details.

3. Change
Check the box that applies to the change requested. Please see the "How to Submit Changes" section in this chapter for further details.

Section B: Employer information
1. Employer name
If not already pre-printed, please add.

2. Control, suffix and account number
If not already pre-printed, please add.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Enrollment (*continued*)

3. Plan number
The plan number reflects the combination of benefits offered under your Group Policy. It details the employees eligible for a particular Policy, the particular benefits covered under each Policy, the plan numbers and basic administrative instructions. If your Group Policy offers more than one combination of benefits, please contact your Aetna representative for the appropriate plan number.

4. SFO (Servicing Field Office)
This information will be pre-printed on your Enrollment/Change Request form.

5. Employer address
The employer's primary business location.

6. Claim office code
The claim office assigned to the Enrollee. Your Aetna representative will provide you with this code.

7. Customer code (optional)
Provide an identifying customer code for the employee (only if you had elected to provide this information).

Section C: Employee information

1. Employee name
The employee should list his/her full name (last, first, middle initial). Do not use nicknames.

2. Birth date
The employee should list his/her date of birth.

3. Employee's sex
Show "M" for male and "F" for female.

4. Telephone numbers
The employee should list his/her home and work phone numbers.

5. Employee home address
The employee should list his/her home address (street, city, state, zip code).

6. Employee coverage amounts
The employee should list his/her annual earnings in whole dollars. Also fill in the amounts of insurance requested for each benefit covered or elected.

7. Beneficiary designation
The employee should list the full name of the beneficiary, the beneficiary's Social Security number and the relationship to the employee. This is necessary to determine to whom benefits will be paid in case of death. If additional space is needed, use the Special Remarks space. Please refer to the Beneficiaries chapter for the appropriate beneficiary terminology.

Section D: Covered dependents
(Complete only if dependent coverage is offered under your Policy and dependent coverage is elected.)

Dependents
Check the box if dependent coverage is being refused.

Transaction type
Show "A" for adding new coverage for an employee or dependent.

Show "C" for changing dependent coverage.

Show "R" to remove a dependent.

Dependent name
The employee should list the dependents' full name (last, first, middle initial). Do not use nicknames.

Social Security number
Fill in the Social Security number of each dependent, if available.

Relation code
Use the following abbreviations to indicate the relationship of each dependent to the employee:

W = Wife

H = Husband

D = Daughter

S = Son

O = Other (Use the Special Remarks section to indicate the relationship, if any, to the covered employee and to provide details of the parent-child relationship.*)

Birth date
The employee must list his/her date of birth and the birth dates of all dependents.

Students age 19 or older
Indicate "yes" if the employee is enrolling a child over the age of 19. Dependent children over age 19 who are not attending school are generally not eligible for coverage.

*If your Group Policy permits employees to cover dependent children who are not their own biological, adopted or stepchildren, it will be necessary to have the employee complete a Special Dependent form. For example, the completion of a Special Dependent form would be required if the employee were attempting to enroll a niece, nephew or grandchild. If the employee is attempting to cover a dependent child who is not his/her own biological, adopted or stepchild, the Special Dependent form shown later in this chapter should be completed and attached to the Enrollment/Change Request form. If the Special Dependent form is not submitted with the Enrollment/Change Request form, a copy will be sent to the employer for completion by the employee. Answers to the questions on the form will be used to determine if the child is eligible for the coverage.

Insurance amount(s)
Fill in the insurance amounts for the benefits elected.

Acknowledgments
Employee's signature
The employee must sign and date the form.

Employee's e-mail address
This is optional.

Employer's signature
The employer must sign and date the form.

When should changes be submitted?

You should use the Enrollment/Change Request form to:

- Add, change or remove dependents
- Change beneficiary information
- Change Social Security number
- Change Plan number
- Change earnings amounts
- Change insurance amounts
- Terminations or cancellations

How should changes be submitted?

You will need to check the box in the "Change" section of the form (section A #3) that corresponds to the change being requested. Then the portion of the form that relates to the change should be filled out. For example, to increase the benefit amount, check the "Increase/Decrease Benefit Amount" box and fill out all the pertinent information in section 6 of the form.

The following information should also be filled out when submitting any change:

Section A: Effective date of transaction
This is the effective date of the change.

Section B: Employer information
Employer name
If not already pre-printed, please add.

Control, suffix and account number
If not already pre-printed, please add.

Section C: Employee information:
Employee's Social Security number
List employee's Social Security number.

Employee's name
The employee should list his/her full name (last, first, middle initial). Do not use nicknames.

Certification
The employee and the employer must sign and date the form.

More information on terminations or cancellations

When processing a termination or cancellation, please use the date the employee's employment terminates or the date the employee cancels his/her coverage. For purposes of credit transactions (crediting premium), the effective date will be limited to 60 days from the date your request is received by Aetna.

The date the employee terminates or cancels coverage can be either:

- The date the employee ceases active work, is no longer in an eligible class or cancels coverage.
- The last day of the billing cycle during which the employee ceases active work, is no longer in an eligible class or cancels coverage. For example, if your next billing due date is November 1 and an employee's last day of work is October 23, you have the option of extending that employee's benefits through October 31, the end of the current billing cycle.

Please provide the reason for terminating or canceling coverage on the Enrollment/Change Request form in section D – Special Remarks.

Note: Any continuation will begin on the day following the date of termination or cancellation of coverage, regardless of which option is elected. All terminations or cancellations under your Policy must be reported the same way. Aetna will process the termination or cancellation as of the date you specify.

Note: There is an important distinction between canceling an employee's coverage and terminating an employee's coverage. The cancellation box should only be checked when the employee cancels his/her coverage, but remains active at work; for example, an employee who remains in your employment but cancels his/her coverage because he or she has opted to become covered under the spouse's Group Policy. The termination box should only be checked when the employee ceases employment or becomes a member of a class of employees not eligible for coverage. This distinction is important because an employee who terminates employment or who rejoins an eligible class within one year of termination will typically not be required to again serve any probationary period of your Group Policy.

Enrollment (*continued*)

Aetna's Privacy Notice

The Notice of Aetna's Privacy Practices describes Aetna's privacy policy. Aetna distributes the required notices to members as required by law. This notice is required by the federal HIPAA Privacy Rule and also by individual state Gramm-Leach-Bliley Privacy Regulations. The notice may differ based on the insured product. If your Policy includes insured coverages, you may obtain copies of product-specific versions of the Notice of Aetna's Privacy Practices, which are available on our website at **www.aetna.com/about/information_ practices.html**.

These privacy notices are not applicable to employees in self-funded benefits plans. Instead, plan sponsors may be obligated to develop and provide employees in self-funded benefits plans with their privacy notice. Please consult your counsel and/or consultants to develop any such required privacy notice.

Additional privacy information

While not a formal part of the employee Booklet/Certificate, the following confidentiality notice is included along with employee Booklet/Certificate to comply with state requirements.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Confidentiality notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or Life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or Life Insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payers (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your policy), other insurers, third-party administrators, vendors, consultants, government authorities and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third-party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and Life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our website at **www.aetna.com**.

Your right of access and correction

In general, you have a right to learn the nature and substance of any information Aetna has in its files about you. You may also have a right of access to such files, except information that relates to a claim or a civil or criminal proceeding, and to ask for correction, amendment or deletion of personal information. This can be done in states that provide such rights and that grant immunity to insurers providing such access. If you request any health information, Aetna may elect to disclose details of the information you request to your (attending) physician. If you wish to exercise this right or if you wish to have more detail on our information practices, please contact:

Aetna
Executive Regulatory & Resolution Team, RT11
151 Farmington Avenue
Hartford, CT 06156

Aetna®

Life Enrollment/Change Request

Aetna Life Insurance Company

A. Transaction Information

1. Enrollment
- ☐ New Employee ☐ Retiree
- ☐ Rehire/Reinstatement

Effective Date (MM/DD/YYYY) _____

Date of Hire (MM/DD/YYYY) _____

Requested Employee Coverage
- ☐ Basic Life
- ☐ AD&PL/AD&D
- ☐ Supplemental Life
- ☐ Supplemental AD&PL/AD&D

Requested Dependent Coverage
- ☐ Basic Dependent Life
- ☐ Basic Dependent AD&PL/AD&D
- ☐ Supplemental Dependent Life
- ☐ Supplemental Dependent AD&PL/AD&D

2. Termination (Cancel)
- ☐ Employee *

* Employee must be enrolled for dependent(s) to have coverage.

Effective Date (MM/DD/YYYY) _____

3. Change (*Provide explanation in Section D, Special Remarks.)
- ☐ Add Dependent(s) ☐ Plan Change
- ☐ Remove Dependent(s) ☐ Other*
- ☐ Increase/Decrease Benefit Amount*

Effective Date (MM/DD/YYYY) _____

B. Employer Information

1. Employer Name - Full Name of Business or Organization	2. Control No.	Suffix	Account	3. Plan Number	4. SFO

5. Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	6. Claim Office Code	7. Customer Code (Optional)

C. Employee Information - Please Print all Information

1. Employee Social Security Number	2. Employee Name (Last, First, M.I.)	3. Birthdate (MM/DD/YYYY)	4. Sex	5. Telephone Numbers
- -		/ /		Home ( ) - Work ( ) -

6. Employee Home Address (Number, Street, Apt. No., City, State, ZIP Code)	7. Employee Annual Earnings	8. Occupation/Title
	$	

9. Employee Coverage Amounts (Based on the requirements of your Plan, you may have to submit evidence of good health.)

Basic Life Amount	Supplemental Life Amount	Basic AD&PL/AD&D Amount	Supplemental AD&PL/AD&D Amount
$	$	$	$

10. Beneficiary Designation - If more than one beneficiary, use Special Remarks. Dependent coverage Beneficiary is always the Employee.

Full Beneficiary Name (First, Middle, Last)	Social Security Number of Beneficiary	Relationship to Employee
	- -	

D. Covered Dependents (Complete only if Dependent Coverage is offered under your Plan.)

☐ Check this box if you are refusing coverage for your dependents.

(A)dd/New (C)hange (R)emove	Dependent Name (First, Middle Initial, Last)	Social Security Number (If dependent has no SSN, write "None")	Relation. Code	Birthdate MM / DD / YYYY	Student Age 19 or Older Yes No	Basic Dependent Amount	Supplemental Dependent Amount	Basic Dependent AD&PL/AD&D Amount	Supplemental Dependent AD&PL/AD&D Amount
		- -		/ /	☐ ☐	$	$	$	$
		- -		/ /	☐ ☐	$	$	$	$
		- -		/ /	☐ ☐	$	$	$	$
		- -		/ /	☐ ☐	$	$	$	$

Special Remarks

E. Certification - Signatures Required

Employee's E-mail Address:

My signature below signifies my agreement with the statements and authorization under **Certification and Authorization** on the back of this form.

1. Employee Signature *(Required)*	Date	2. Employer Signature *(Required)*	Date
X		X	

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Beneficiaries

How to assign coverage

Assignment

Assignment is the process by which a covered employee transfers his/her incidents of ownership under the Group Policy to another individual, individuals, trust or organization. Please note that Aetna's policy prohibits assignments unless you (the policyholder) agree to it.

What if an employee wants to assign his or her Life Insurance and/or AD&PL coverage?

- Call the Life Insurance Service Center toll-free at 1-800-523-5065 to request the appropriate assignment forms.
- Advise the employee that he or she may wish to discuss assignment tax implications and legal issues with an attorney or tax advisor prior to completing the assignment.

What is the process for assigning coverage?

- Work with the employee (assignor) to complete four copies of the assignment forms that Aetna sends you.
- Make sure the assignee completes and dates the four forms in the Release by Assignee sections.
- Sign the four forms in the appropriate sections.
- Return the four completed forms to Aetna.

What will Aetna do when it receives the assignment forms?

- Review the forms for proper completion and execution.
- Contact the employer or employee to resolve any problems.
- Register and place on file properly completed and executed assignments.
- Aetna will return three executed copies to you. Retain one and give two to the employee for record keeping.

By placing the assignment on file, Aetna assumes no responsibility for the validity, sufficiency or effect of the assignment.

When does the assignment become effective?

The assignment becomes effective on the date the designated assignee accepts the assignment.

How to complete an Assignment of Group Coverage form

The employee must fill out the form and must follow these instructions whether the employee (the assignor) elects to assign his/her coverage to a single assignee or to multiple assignees. A sample form is shown later in this chapter.

When completing the appropriate forms, it is important that the assignee(s), assignor and the employer complete all four forms, as Aetna cannot accept photocopies.

Once the assignment has been registered by us and returned to you, it is essential that you mark the employee's file to show that the rights have been assigned. In the event that the employee dies while an assignment is in effect, the registered Assignment of Group Coverage form should be submitted with the Proof of Death form.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Beneficiaries (*continued*)

Front side:

1. Print the insured's full name (do not use nicknames or abbreviations).
2. Write in the insured's Social Security number.
3. Print the assignor's full name (do not use nicknames or abbreviations).
4. Print the assignee's full name (do not use nicknames or abbreviations). If the assignee is a trust, enter the name of the trust, the trust agreement date and the trustee(s).
5. Include the assignee's relationship to the assignor, if any. If not related, indicate "none."
6. Write in the assignee's Social Security number (not necessary for a trust).
7. Provide the assignee's home address (street, city, state and zip code). If the assignee is a trust, enter the trustee's address. Repeat steps 4–7 if more than one assignee.
8. Provide the six-digit control number.
9. If the assignor is covered under more than one Group Policy, list the other Aetna control numbers if the assignor is assigning benefits under all group life policies.
10. Provide the full name of the policyholder.
11. Provide the city/town and state where the assignor is at the time he or she completes the form, plus the day, month and year. Be sure to use a current date.
12. A disinterested person must witness the assignor's signature. (A disinterested person is defined as someone who has no interest in the assignment.)
13. The signature of the assignor.

Reverse side:

Release by assignee

A disinterested person must witness the assignee's signature. (A disinterested person is defined as someone who has no interest in the assignment.)

1. The form must be signed and dated by the assignee.

Consent by contract holder

This section must be completed by you, the employer.

1. Provide the full name of the employer.
2. Include the date the employer completes this section.
3. The person authorized to complete the form for the employer must provide his/her signature and must print his/her full name next to the signature.
4. Provide the title of the person who completes this section.

Consent by insurer and acknowledgement of recording

Aetna will complete this section.

Designation of beneficiary by assignee

1. It is recommended that the assignee name a beneficiary at the time this form is executed. If the assignee does not name a beneficiary, Aetna may still register the form. If the assignee decides to designate a beneficiary later, Aetna will furnish the Designation of Beneficiary by Assignee forms to be completed.
2. A disinterested person must witness the assignee's signature. (A disinterested person is defined as someone who has no interest in the assignment.)
3. The assignee must provide his/her signature.

Aetna

Assignment of Group Coverage

Aetna Life Insurance Company

Name of Person Insured	
Social Security Number	

Mail all four originally signed copies to:

Aetna Life Insurance Company
Attn: Consumer Services
151 Farmington Avenue
Hartford, CT 06156-7318

To be executed in quadruplet - May be used for Group Life Coverage with or without Paid-Up Values, Group Accidental Death and Dismemberment, and Group Plans providing Accident Coverage. May also be used for individual policies provided on a group basis such as policy forms GR-42645, GR-37, GR-159 and GR-1072. If the employee lives in a community property state, and if the employee's spouse is not an assignee, said spouse should assent in writing to the assignment.

Aetna makes no representation that this assignment form is sufficient for purposes of an employee's personal tax or estate planning. Prior to making any assignment, employees should review this form with their own legal counsel. **NO ONE SHOULD COMPLETE THIS FORM IF HE OR SHE HAS EXECUTED A PREVIOUS ASSIGNMENT WHICH HAS BEEN ACCEPTED BY AETNA IN CONNECTION WITH ANY OF THE ABOVE-MENTIONED COVERAGES AND WHICH IS CURRENTLY IN FORCE.**

I, the undersigned, _____, hereby irrevocably assign, transfer, and set over as a
Assignor

gift to

Assignee	Family Relationship, if any	Social Security Number
Street Address	City or Town, State	

and to the executors, administrators, successors or assigns of said assignee all my incidents of ownership, including but not limited to all my right, title, claim, interest and benefit, present or future, in and to any Group Insurance benefit which becomes payable on account of my death or the death of any of my dependents under Contract No.(s) _____ _____ a contract or contracts between the Contractholder, namely, _____, and the Insurer, namely, Aetna Life Insurance Company or one of its affiliated Companies, and under any contract or contracts issued by the Insurer or any succeeding Insurer to the Contractholder, its successors or assigns, in replacement thereof, and under any individual contract or contracts issued by the Insurer or any succeeding Insurer pursuant to the conversion privilege contained in such contract or contracts.

Without limiting in any way the generality of the foregoing, this assignment shall vest in the assignee or in his executor or administrator should the assignee predecease me: (1) the sole and exclusive right to exercise the privilege of obtaining an individual contract of life insurance in accordance with any conversion privilege contained in the contract or contracts; (2) the right to make to the Contractholder any contributions which may be required to maintain my insurance in force under the contract or contracts; (3) the sole and exclusive right to exercise any and all other rights, privileges, and options which, but for this assignment, could be exercised by me under the contract or contracts, or which may be granted by the Insurer; (4) the sole and exclusive right to demand, collect, and receive any and all proceeds of the contract or contracts, subject, however, to the terms of the contract and subject further to the right of the assignee to designate and to change the beneficiary as provided in the contract or contracts.

If this assignment is made to the assignee as trustee, or is subject to any condition or agreement, neither the Contractholder nor the Insurer shall be obliged to inquire into the terms of such trust, condition or agreement, and they shall not be chargeable with knowledge of the terms thereof. The Contractholder and the Insurer may rely solely upon the signature of the assignee to any release, receipt or waiver, or to any other instrument affecting this assignment of my insurance under the contract or contracts.

In the event the contract or contracts contain a provision against assignments, it is understood that this assignment shall not take effect until the Contractholder and the Insurer execute waivers thereof, and that after such execution this assignment shall become effective as of the date of acceptance by the Assignee, as indicated on the reverse side.

It is further understood that neither the Contractholder nor the Insurer assumes responsibility of any kind or degree for the validity, sufficiency or effect of this assignment.

IN WITNESS WHEREOF, I have hereunto set my hand at _____, this _____ day of _____, 20___.

Signed and delivered in the presence of:

Witness	Assignor

GR-60840-7 (4-06) Single Assignee

Assignment of Group Coverage - Single

Release By Assignees

I have accepted the assignment set forth on the reverse side hereof. It is my understanding that the contract or contracts under which the assignor's benefits are provided contain a prohibition against their assignment, and that the assignment to me will not be effective unless the Contractholder and the Insurer consent thereto. In consideration of their grant of such consent, I hereby agree to release the Contractholder and the Insurer, their employees, agents, and assigns from any obligation or liability of any kind that might arise as a consequence of the assignment. In particular, I hereby release each of them from any liability for any failure to notify me of changes in the insurance benefits assigned to me or of any termination hereof, or of any act required by me to keep said benefits in force.

Witness	Assignee	Date

Consent by Contractholder

In consideration of the execution by the assignee of the above "**Release By Assignee**," the Contractholder hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other.

Contractholder	Date

By	Title

Consent by Insurer and Acknowledgment of Recording

In consideration of the execution by the assignee of the above "**Release By Assignee**," the Insurer hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other. A copy of this assignment has been placed on file by the Insurer.

Insurer	

By	Title

Registrar	Date

Designation of Beneficiary By Assignees

Effective on the date of my acceptance of the assignment set forth on the reverse side hereof and in accordance with my right as assignee, I hereby designate **one***, of the following as the beneficiary under the contract or contracts set forth in said assignment to receive any sum becoming payable by reason of death of the person insured:

☐ Myself, if I survive the insured, otherwise in equal shares to my surviving children, and the descendants of any deceased child per stirpes.

☐ Myself, if I survive the insured, otherwise in equal shares to my surviving children.

☐ Myself, if I survive the insured, otherwise to my estate.

☐ Other, _____

☐ _____, as Trustee under Trust Agreement dated _____.

***NOTE: If assignee wishes to make any other Designation of Beneficiary, the Insurer will promptly furnish proper forms on request.**

It is my understanding and desire that this Designation shall operate so as to revoke any and all designations of beneficiary previously made under said contract or contracts; that this Designation is subject to change as provided in said contract or contracts; that if the Designation is to a trust, the Insurer shall not be chargeable with knowledge of the terms thereof and the payment to and receipt by the trustee(s) shall fully discharge all liability of said Insurer to the extent of such payment; and that this Designation will not affect the payment of survivor income benefits if the contract or contracts under which such benefits are provided make no provision for a beneficiary designation.

Witness	Assignee

Assignment of Group Coverage - Multiple

Aetna

Assignment of Group Coverage

Aetna Life Insurance Company

Name of Person Insured	
Social Security Number	

Mail all four originally signed copies to:

Aetna Life Insurance Company
Attn: Consumer Services
151 Farmington Avenue
Hartford, CT 06156-7318

To be executed in quadruplet - May be used for Group Life Plans with or without Paid-Up Values, Group Plans providing benefits for Accidental Death and Dismemberment, and Group Accident Plans. May also be used for individual policies provided on a group basis such as policy forms GR-42645, GR-37, GR-159 and GR-1072. If the employee lives in a community property state, and if the employee's spouse is not an assignee, said spouse should assent in writing to the assignment.

Aetna makes no representation that this assignment form is sufficient for purposes of an employee's personal tax or estate planning. Prior to making any assignment, employees should review this form with their own legal counsel. **NO ONE SHOULD COMPLETE THIS FORM IF HE OR SHE HAS EXECUTED A PREVIOUS ASSIGNMENT WHICH HAS BEEN ACCEPTED BY AETNA IN CONNECTION WITH ANY OF THE ABOVE-MENTIONED COVERAGES AND WHICH IS CURRENTLY IN FORCE.**

I, the undersigned, _____, hereby irrevocably assign, transfer, and set over as a gift to
Assignor

Assignee	Family Relationship, if any	Social Security Number
Street Address	City or Town	
Assignee	Family Relationship, if any	Social Security Number
Street Address	City or Town	
Assignee	Family Relationship, if any	Social Security Number
Street Address	City or Town	

in equal shares, or to the survivor, all my incidents of ownership, including but not limited to all my right, title, claim, interest and benefit, present or future, in and to any Group Insurance benefit which becomes payable on account of my death or the death of any of my dependents under Contract No.(s) _____
a contract or contracts between the Contractholder, namely, _____, and the Insurer, namely, Aetna Life Insurance Company or one of its affiliated Companies, and under any contract or contracts issued by the Insurer or any succeeding Insurer to the Contractholder, its successors or assigns, in replacement thereof, and under any individual contract or contracts issued by the Insurer or any succeeding Insurer pursuant to the conversion privilege contained in such contract or contracts.

Without limiting in any way the generality of the foregoing, this assignment shall vest in the assignees or in the survivor or in the estate of the last surviving assignee should the assignees predecease me: (1) the sole and exclusive right to exercise the privilege of obtaining an individual contract of life insurance in accordance with any conversion privilege contained in the contract or contracts; (2) the right to make to the Contractholder any contributions which may be required to maintain my insurance in force under the contract or contracts; (3) the sole and exclusive right to exercise any and all other rights, privileges, and options which, but for this assignment, could be exercised by me under the contract or contracts, or which may be granted by the Insurer; (4) the sole and exclusive right to demand, collect, and receive any and all proceeds of the contract or contracts, subject, however, to the terms of the contract and subject further to the right of the assignee to designate and to change the beneficiary as provided in the contract or contracts.

If this assignment is made to the assignees as trustees or is subject to any condition or agreement, neither the Contractholder nor the Insurer shall be obliged to inquire into the terms of such trust, condition or agreement, and they shall not be chargeable with knowledge of the terms thereof. The Contractholder and the Insurer may rely solely upon the signature of the assignees to any release, receipt or waiver, or to any other instrument affecting this assignment of my insurance under the contract or contracts.

In the event the contract or contracts contain a provision against assignments, it is understood that this assignment shall not take effect until the Contractholder and the Insurer execute waivers thereof, and that after such execution this assignment shall become effective as of the date of acceptance by the Assignees, as indicated on the reverse side.

It is further understood that neither the Contractholder nor the Insurer assumes responsibility of any kind or degree for the validity, sufficiency or effect of this assignment.

IN WITNESS WHEREOF, I have hereunto set my hand at _____, this _____ day of _____, 20 ___.

Signed and delivered in the presence of:

Witness	Assignor

GR-60840-8 (4-06) Multiple Assignees

Assignment of Group Coverage - Multiple

Release By Assignees

We have accepted the assignment set forth on the reverse side hereof. It is our understanding that the contract or contracts under which the assignor's benefits are provided contain a prohibition against their assignment, and that the assignment to us will not be effective unless the Contractholder and the Insurer consent thereto. In consideration of their grant of such consent, we hereby agree to release the Contractholder and the Insurer, their employees, agents, and assigns from any obligation or liability of any kind that might arise as a consequence of the assignment. In particular, we hereby release each of them from any liability for any failure to notify us of changes in the insurance benefits assigned to us or of any termination thereof, or of any act required by us to keep said benefits in force.

Witness	Assignee	
Witness	Assignee	Date
Witness	Assignee	

Consent by Contractholder

In consideration of the execution by the assignees of the above "**Release By Assignees**," the Contractholder hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other.

Contractholder	Date
By	Title

Consent by Insurer and Acknowledgment of Recording

In consideration of the execution by the assignee of the above "**Release By Assignees**," the Insurer hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other. A copy of this assignment has been placed on file by the Insurer.

Insurer	
By	Title
Registrar	Date

Designation of Beneficiary By Assignees

Effective on the date of our acceptance of the assignment set forth on the reverse side hereof and in accordance with our right as assignees, we hereby designate **one***, of the following as the beneficiary(ies) under the contract or contracts set forth in said assignment to receive any sum becoming payable by reason of death of the person insured:

- ☐ _____ spouse of said person insured, if he or she survives the insured, otherwise in equal shares to the surviving assignees named in the foregoing assignment and the descendants of any deceased assignee, per stirpes.
- ☐ In equal shares to the surviving assignees named in the foregoing assignment and the descendants of any deceased assignee, per stirpes.
- ☐ In equal shares to the surviving assignees named in the foregoing assignment.
- ☐ Other, _____
- ☐ _____, as Trustee under Trust Agreement dated _____.

***NOTE: If assignees wish to make any other Designation of Beneficiary, the Insurer will promptly furnish proper forms on request.**

It is our understanding and desire that this Designation shall operate so as to revoke any and all designations of beneficiary previously made under said contract or contracts; that this Designation is subject to change as provided in said contract or contracts; that if the Designation is to a trust, the Insurer shall not be chargeable with knowledge of the terms thereof and the payment to and receipt by the trustee(s) shall fully discharge all liability of said Insurer to the extent of such payment; and that this Designation will not affect the payment of survivor income benefits if the contract or contracts under which such benefits are provided make no provision for a beneficiary designation.

Witness	Assignee
Witness	Assignee
Witness	Assignee

Aetna

Assignment of Group Coverage

Aetna Life Insurance Company

Name of Person Insured	
Social Security Number	

Mail all four originally signed copies to:

Aetna Life Insurance Company
Attn: Consumer Services
151 Farmington Avenue
Hartford, CT 06156-7318

To be executed in quadruplet- May be used for Group Life Coverage with or without Paid-Up Values, Group Accidental Death and Dismemberment, and Group Plans providing Accident Coverage. May also be used for individual policies provided on a group basis such as policy forms GR-42645, GR-37, GR-159 and GR-1072. If the employee lives in a community property state, and if the employee's spouse is not an assignee, said spouse should assent in writing to the assignment.

Aetna makes no representation that this assignment form is sufficient for purposes of an employee's personal tax or estate planning. Prior to making any assignment, employees should review this form with their own legal counsel. **NO ONE SHOULD COMPLETE THIS FORM IF HE OR SHE HAS EXECUTED A PREVIOUS ASSIGNMENT WHICH HAS BEEN ACCEPTED BY AETNA IN CONNECTION WITH ANY OF THE ABOVE-MENTIONED COVERAGES AND WHICH IS CURRENTLY IN FORCE.**

I, the undersigned, _____, hereby irrevocably assign, transfer, and set over for
Assignor

value to _____
Assignee

_____ _____ _____, and to the
Street Address City State

successors or assigns of said assignee all my incidents of ownership, except to the extent prohibited by law, including but not limited to all my right, or future, in and to my insurance under Contract Number(s) _____ a contract or contracts between the Contractholder, namely, _____, and the Insurer, namely, Aetna Life Insurance Company or one of its affiliated Companies, and under any contract or contracts issued by the Insurer or any succeeding Insurer to the Contractholder, its successors or assigns, in replacement thereof, and under any individual contract or contracts issued by the Insurer or any succeeding Insurer pursuant to the conversion privilege contained in such contract or contracts.

Without limiting in any way the generality of the foregoing, this assignment shall vest in the assignee (1) the sole and exclusive right to exercise the privilege of obtaining an individual contract of life insurance in accordance with any conversion privilege contained in the contract or contracts; (2) the right to make to the Contractholder any contributions which may be required to maintain my insurance in force under the contract or contracts; (3) the sole and exclusive right to exercise any and all other rights, privileges, and options which, but for this assignment, could be exercised by me under the contract or contracts, or which may be granted by the Insurer; (4) the sole and exclusive right to demand, collect, and receive any and all proceeds of the contract or contracts, subject, however, to the terms of the contract and subject further to the right of the assignee to designate and to change the beneficiary as provided in the contract or contracts.

If this assignment is made to the assignee as trustee, or is subject to any condition or agreement, neither the Contractholder nor the Insurer shall be obliged to inquire into the terms of such trust, condition or agreement, and they shall not be chargeable with knowledge of the terms thereof. The Contractholder and the Insurer may rely solely upon the signature of the assignee to any release, receipt or waiver, or to any other instrument affecting this assignment of my insurance under the contract or contracts.

In the event the contract or contracts contain a provision against assignments, it is understood that this assignment shall not take effect until the Contractholder and the Insurer execute waivers thereof, and that after such execution this assignment shall become effective as of the date of acceptance by the Assignee, as indicated on the reverse side.

It is further understood that neither the Contractholder nor the Insurer assumes responsibility of any kind or degree for the validity, sufficiency or effect of this assignment.

IN WITNESS WHEREOF, I have hereunto set my hand at _____, this ____ day of _____, 20 ____.

Signed and delivered in the presence of:

Witness	Assignor

Assignment of Group Coverage – Viatical

Release By Assignee

I have accepted the assignment set forth on the reverse side hereof. It is my understanding that the contract or contracts under which the assignor's benefits are provided contain a prohibition against their assignment, and that the assignment to me will not be effective unless the Contractholder and the Insurer consent thereto. In consideration of their grant of such consent, I hereby agree to release the Contractholder and the Insurer, their employees, agents, and assigns from any obligation or liability of any kind that might arise as a consequence of the assignment. In particular, I hereby release each of them from any liability for any failure to notify me of changes in the insurance benefits assigned to me or of any termination hereof, or of any act required by me to keep said benefits in force.

Witness	Assignee	Date

Consent by Contractholder

In consideration of the execution by the assignee of the above "**Release By Assignee**," the Contractholder hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other.

Contractholder		Date
By	Title	

Consent by Insurer and Acknowledgment of Recording

In consideration of the execution by the assignee of the above "**Release By Assignee**," the Insurer hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other. A copy of this assignment has been placed on file by the Insurer.

Insurer		
By	Title	
Registrar		Date

Funeral Home Beneficiary Designation

Funeral Home Beneficiary Designation

Aetna Life Insurance Company

Aetna Life Insurance Company
Attn: Consumer Services
151 Farmington Avenue, RE52
Hartford, CT 06156-7318

Please type or print.

Group Policyholder	Group Policy(ies)

Name of Employee	Employee Social Security Number

Subject to the terms of the above numbered Group Policy(ies), I request that from any sum becoming payable by reason of my death, Aetna Life Insurance Company may pay an amount not to exceed $ _____* toward funeral services provided by the following funeral home but only to the extent that such funeral home provides these services.

**Amount to be inserted in this space may not exceed the scheduled benefit and should not exceed $10,000, except with written consent of Insurance Company.*

Funeral Home

Address

The remainder of said sum, if any, shall be payable to the following secondary beneficiary(ies). (If more than one named, the secondary beneficiaries shall share equally unless otherwise stated below).

Name of Beneficiary	Relationship	Social Security Number	Address of Beneficiary	Percentage
Name of Beneficiary	**Relationship**	**Social Security Number**	**Address of Beneficiary**	**Percentage**

Unless otherwise expressly provided above, if any secondary beneficiary hereby designated predeceases me, the share which such beneficiary would have received if such beneficiary had survived me, shall be payable equally to the remaining secondary beneficiary(ies), if any, who survive me. If no secondary beneficiary survives me, I request that said remainder be payable as prescribed in said Group Policy(ies).

The foregoing Beneficiary Designation shall extend to any insurance which may be in effect on my life in replacement of my insurance under said Group Policy(ies).

If this Beneficiary Designation refers only to Group Life Insurance coverage and I am also insured for Group Accidental Death and Dismemberment coverage, this designation shall apply to both policies unless otherwise expressly stated above. This Beneficiary Designation shall not apply to coverage, if any, under a Group Accident policy bearing the prefix ACC.

The right to change this designation of beneficiary is reserved in accordance with the terms of the group policy(ies) under which I may be insured at the time such change of beneficiary is requested.

Signed at _____ this _____ day of _____, 20 _____.

Witness _____ _____
Witness Signature of Insured

A copy of this agreement has been placed on file.

Hartford, Connecticut, this _____ day of _____, 20 _____.

Insurer **Aetna Life Insurance Company**	
By	**Title**

Registrar	Date

GR-834 (8-05)

Creditor Designation of Beneficiary

Creditor Designation of Beneficiary
Aetna Life Insurance Company

Aetna Life Insurance Company
Attn: Consumer Services
151 Farmington Avenue, RE52
Hartford, CT 06156-7318

Instructions: This form should be typed or printed in triplicate, then the Group Contractholder should forward all copies to: Aetna Life Insurance Company, Attn: Consumer Services, 151 Farmington Avenue, RE52, Hartford, CT 06156-7318.

Group Contractholder	Group Contract Number(s)

Employee's Name	Social Security Number

Subject to the terms of the above numbered Group Contract(s), I request that any sum becoming payable by reason of my death be payable to the following creditor beneficiary, as interest may appear:

Name of Creditor	Address

The interest of said creditor in said sum shall be the unpaid balance of any indebtedness now or hereafter owed said creditor by me and any amounts expended by said creditor for funeral and other expenses incident to my last illness and death. Aetna Life Insurance Company is authorized to accept the affidavit of the creditor as sufficient proof of his interest in said sum, and shall be absolved of all liability in acting in reliance thereon.

The remainder of said sum, if any, shall be payable to the following secondary beneficiary(ies). (If more than one named, the secondary beneficiary shall share equally unless otherwise stated below.)

Name of Beneficiary		Address of Beneficiary
Social Security Number	Relationship	

Name of Beneficiary		Address of Beneficiary
Social Security Number	Relationship	

The foregoing Designation of Beneficiary shall extend to any insurance which may be in effect on my life in replacement of my insurance under said Group Contract(s).

If this Designation of Beneficiary refers only to a Group Life Insurance contract and I am also insured for Group Accidental Death and Dismemberment coverage, this designation shall apply to both policies unless otherwise expressly stated above. This Designation of Beneficiary shall not apply to coverage, if any, under a Group Accident contract bearing the prefix ACC.

I hereby agree not to make any change in beneficiary which will affect the interest of said creditor beneficiary without the written consent of said creditor, but this Designation of Beneficiary is otherwise subject to change as provided in the contract or contracts in effect at the time such change of beneficiary is requested.

The designation of said creditor beneficiary shall not apply at any time after my Paid-up Insurances, if any, become subject to surrender by me for cash value, and nothing herein shall restrict in any way my right to surrender such Paid-up Insurances upon or at any time after termination of my employment.

Signed in triplicate at _____ this _____ day of _____, 20 ___.

_____ _____
Witness **Signature of Person Insured - Full Name**

Approved _____ Group Contractholder

By _____ _____
(Its Duly Authorized Representative) **Registrar**

HARTFORD, CONNECTICUT, this _____ day of _____, 20 ___.

A copy of this agreement has been placed on file.

GR-999-2 (8-05)

Beneficiaries (*continued*)

Beneficiary designations and changes

Who can designate or change beneficiaries?

- Employees with Life Insurance and/or Accidental Death and Personal Loss coverage have the right to name the beneficiary(ies) of their choice. A beneficiary is the person who receives benefits when an insured dies.
- Beneficiary changes made by an individual acting as an agent under a durable power of attorney.
- Covered dependents cannot designate beneficiaries. Benefits are always payable to the insured employee or his/her estate.

The guidelines for changing a beneficiary using a Durable Power of Attorney are found on page 26.

When can employees designate beneficiaries?

Employees can first designate a beneficiary(ies) at enrollment or at any time thereafter.

Can employees change beneficiaries?

Employees have the right to change their named beneficiaries at any time by following the instructions shown in this section.

What if an employee does not designate a beneficiary?

If an employee has not designated a beneficiary at the time of the employee's death, Life Insurance benefits will be paid in accordance with the Beneficiary section of your Group Policy.

What if the beneficiary dies before the employee?

If a named beneficiary is not alive at the time of the employee's death, Life Insurance benefits will be paid in accordance with the Beneficiary section of your Group Policy.

What is the process for designating a beneficiary?

Employees can designate a beneficiary on the Enrollment/Change Request form or submit a written request to you or to Aetna's corporate headquarters. In any event, the beneficiary designation should include:

- The employee's signature and date signed.
- The full name of the beneficiary or organization (no nicknames).
- The relationship of the beneficiary to the insured (for example, spouse, trust, charity).
- The beneficiary's date of birth.
- The beneficiary's Social Security number or tax identification number.

What if a beneficiary designation is incomplete or contains errors?

If any of the above information is missing, the intended beneficiary may not receive the insurance benefits. You should check the form to make sure it is completed correctly, and if not, please contact your employee to obtain any missing information.

Addressing employee questions about designating beneficiaries

Employees should be advised to contact an attorney with any legal questions they may have. They may also contact the Life Insurance Service Center with any other questions. In addition, Aetna suggests the following guidelines for properly identifying and naming different types of beneficiaries. This information may be helpful to your employees so that their wishes are carried out.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Beneficiaries (*continued*)

Individual beneficiaries

When naming an individual as the beneficiary, an employee must include all the information requested above and make sure that the name and the relationship of the person is clear. For example:

Intended Beneficiary	Proper Terminology
Spouse	Jane L. Doe – Wife
Husband	John L. Doe – Husband
Child	John L. Doe Jr. – Son
Fiancée	Mary K. Smith – Fiancée
Friend	Mark A. Jones – Friend

Multiple beneficiaries

When naming more than one person as beneficiary, include all the information requested above in addition to the specific percentages for each beneficiary. All the beneficiaries' percentages added together should equal 100 percent.

Employees may designate primary and contingent beneficiaries. Beneficiaries will receive the benefit upon the employee's death. If the primary beneficiary is not alive at the employee's death, the benefit will be payable to the contingent beneficiary. As shown in the examples that follow, primary and contingent beneficiaries need to be clearly stated in order to avoid discrepancies. For example:

Intended Beneficiary	Proper Terminology
Jane L. Doe, Wife – Primary Children – Secondary	Jane L Doe, Wife – Primary Jeff Doe, Son – Contingent 50% Lucy Doe, Daughter – Contingent 50%
John L. Doe, Husband – Primary Children of Marriage – Secondary	John L. Doe, Husband – Primary Michael S. Doe, Son – Contingent 50% Kevin M. Doe, Son – Contingent 50%
Parents – Primary Joe & Peg C. Doe, Children – Secondary	Esther M. Doe, Mother – Primary 50% George M. Doe, Father – Primary 50% Joe A Doe, Son – Contingent 50% Peg C. Doe, Daughter – Contingent 50%
Spouse and Children – equally	Jane L. Doe, Wife – Primary John L. Doe Jr., Son – Primary Janet L. Doe, Daughter – Primary
Children of John L. Doe	John L. Doe Jr., Son – Primary 50% Janet L. Doe, Daughter – Primary 50%

The beneficiary is the employee's estate

When naming the estate as the beneficiary, include reference to the specific will and date the will was executed. For example:

Intended Beneficiary	Proper Terminology
Estate	The Estate of John L. Doe

Aetna requires a certified copy of the Letters of Testamentary issued by a probate court when there is a will. If there is no will, a "Letter of Administration" issued by the probate court is required.

If the estate is not going through formal probate administration and the amount involved is small, the individual who is settling the estate may obtain the right to the proceeds by complying with the applicable small estate procedure under state law.

The beneficiary is a trust

When naming a "trust" as the beneficiary, the employee should make sure it is a legally established trust. The employee should consult a lawyer for guidance on this issue. If an employee names a trust as beneficiary, at his/her death, a copy of the trust documents will need to be provided. Benefits will be issued to the trustee designated in the trust document.

The beneficiary is a charity, hospital or church

When naming a charity, hospital or church as the beneficiary, include the entity's full name and address. For example:

Intended Beneficiary	Proper Terminology
Charity	American Cancer Society P.O. Box 999 Anywhere, CT 00000
Hospital	Hartford Mercy Hospital 100 Wells Rd Anywhere, CT 00000
Church	St. Marks Church 100 Holy Rd. Anywhere, CT 00000

Additional information helpful to employees selecting beneficiaries

The beneficiary resides in a community property state

In community property states, the employee's spouse may have a legal right to a portion of the Life Insurance benefit, up to a maximum of 50 percent of the benefits. If the employee names someone other than the spouse as beneficiary, and the spouse does not sign the spousal consent section of the beneficiary form, then the spouse has the right to contest the beneficiary designation and payment may be delayed pending a resolution of the spouse's claim to benefits.

Currently, the following states are community property states: Arizona, California, Idaho, Louisiana, New Mexico, Nevada, Texas, Wisconsin and Washington.

The beneficiary is the employer

State law generally prohibits an employee from naming his/her employer as beneficiary. However, if the employer is a charity, the beneficiary designation should indicate the beneficiary as a charity after the organization's name.

The beneficiary is a citizen of a blocked country

If the beneficiary is a citizen or resident of a "blocked country" as determined by Presidential Order, Life Insurance benefits cannot be released to the foreign resident, unless the Department of Treasury, Foreign Assets Control Division, permits the release of the benefit. In the meantime, Aetna will maintain the benefits in a blocked bank account.

The beneficiaries or their representatives, who are citizens and residents of blocked countries, may write to the following address for additional details:

Office of Foreign Assets Control
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220
202-622-2490

The beneficiary is an animal

Employees should be advised that they cannot name an animal as beneficiary, since the animal is not capable of negotiating a draft. Arrangements for the care of an animal can be made through a friend, trust or will.

The beneficiary is a former spouse

Several states have laws under which the designation of a spouse as a Life Insurance beneficiary will be automatically revoked upon divorce (that is, "revocation by divorce" laws). For claims arising under an ERISA-governed policy, a state law that purports to automatically revoke a beneficiary designation will be pre-empted by ERISA and Aetna will pay benefits in accordance with a validly executed beneficiary designation. For policies that are not governed by ERISA, there is no pre-emption of the state "revocation by divorce" law. In this situation, Aetna will review the state's revocation by divorce statute to determine if it is applicable. Claims will be paid in accordance with the terms of the Group Policy and results of that review.

If a former spouse disputes a claim based on the terms of a domestic relations order, then Aetna will need to review the order to ascertain its effect on the claim determination.

The beneficiary is a minor

When a minor child is the beneficiary, the minor does not have the legal capacity to provide a valid release of benefits. Benefits can be distributed only upon receipt of a valid release. Aetna may pay the proceeds for the benefit of the minor if in receipt of:

- A copy of the court order appointing a guardian of the minor's estate (property) and a release by the guardian; and
- A copy of a court order authorizing release; or
- Proof that the child has attained legal age in his/her state of residence; or
- Any other documentation providing a legal release (that is, state statute).

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Beneficiaries (*continued*)

Beneficiary changes made by an individual acting as an agent under a durable power of attorney

The general rule is that the right to designate a Life Insurance beneficiary may only be exercised by the covered employee. However, in some limited circumstances, a third party other than the covered employee may be able to properly execute a beneficiary designation.

For example, if the covered employee has assigned all their rights under the Policy to an assignee, then the assignee, not the covered employee, is the only party that can make or change the beneficiary designation. (For more information, refer to the Beneficiary Assignment section.)

Another example is where the covered employee has designated a person (called an "agent") to act on his/her behalf pursuant to a power of attorney (POA). Whether an agent can make (or change) a beneficiary designation on behalf of the covered employee depends on the applicable state law. If the state POA law specifically permits an agent under a POA to designate a beneficiary on behalf of the covered employee and the POA contains language giving the agent such authority, then a beneficiary designation executed by the POA may be valid. If, however, the applicable state POA law does not specifically allow an agent to execute beneficiary designations under a POA, then the agent can not legally designate a beneficiary (or change an existing beneficiary designation) on behalf of the covered employee.

If you receive a beneficiary designation which has been executed by an agent on behalf of the covered employee, please send a copy of the POA to the address for submitting Proof of Death claims (as shown in the Customer Service Information chapter of this handbook) for review.

Addressing employee concerns about beneficiary issues that may arise after death

Certain situations may occur after the death of the insured. Aetna will rely on the following guidelines and procedures for managing the situations described in the next column.

The claim is disputed

In the event a claim is made by someone other than the beneficiary and that claim appears to lack merit, Aetna will send the individual a letter putting him/her on notice that the claim must be supported on a legal or factual basis within a specified period of time or the payment will be made to the beneficiary of record.

If the claim is substantiated, or it is unclear who is legally entitled to the proceeds, an attempt will be made to obtain an agreement of the parties regarding distribution, or the proceeds may be paid into court pursuant to an interpleader action. If the parties are in the process of negotiating an agreement, the interpleader action will be deferred for a reasonable period of time.

The claim is denied

A review of the denied claim may be requested. The request must be submitted in writing within 60 days after the receipt of the denial. The reason for requesting the review must be included and submitted to Aetna.

Evidence of Insurability

There are circumstances when the employee and/or dependent(s) must submit evidence of good health, referred to as Evidence of Insurability (EOI) in order to be covered under the Group Policy. Aetna requires Evidence of Insurability for late enrollees, elections exceeding the guarantee issue amount or under certain circumstances, subsequent benefit increases after initial enrollment.

When is Evidence of Insurability required for a timely enrollee?

Evidence guidelines for timely enrollees:

- Evidence underwriting for Life Insurance is based on the dollar amount of coverage being requested. Medical Evidence is not needed for amounts under the Guaranteed Issue limit. An Evidence Statement is required for any amount which exceeds the Guaranteed Issue limit. In addition, medical information in the form of questionnaires and attending physician's reports may be required based on the medical history provided on the Evidence application. All requests for additional medical information on timely enrollees, such as an attending physician's report, will be at Aetna's expense.
- Enrollees who have exceeded the non-medical examination maximum will be asked to undergo a paramedical examination, again at Aetna's expense.

When is evidence required for late enrollees?

A "Late" enrollee is an individual who:

- Does not enroll for coverage when initially eligible (within 31 days of completing their probationary period).
- Cancels or freezes coverage and then requests an opportunity to re-enroll or increase coverage at a later date.
- Requests an increase in coverage greater than the Annual Benefits Election rules (one times annual earnings or one unit of coverage).

Evidence of Insurability guidelines for late enrollees

Evidence underwriting is based on the dollar amount of coverage being requested. Any employee or dependent that is late in applying for benefits must complete an Evidence of Insurability Statement. He or she must submit this form for any coverage amount and be approved for that amount before insurance can become effective.

All requests for additional medical information, such as an attending physician's report or a paramedical examination, will be at the enrollee's expense.

Is Evidence of Insurability required for a change in family status?

Employees who are not currently insured for Supplemental Life coverage and undergo a family status change may add Supplemental Life Insurance in the amount or benefit increment (if Policy is based on flat dollar amounts) as indicated in the Policy–without evidence. This request for coverage must be made within 31 days of the family status change. Amounts requested above the Policy stated salary multiple or benefit increment will be subject to evidence and must be medically underwritten. The employee must be approved before the additional coverage would become effective.

Employees who are currently insured for Supplemental Life coverage and undergo a family status change may increase their Supplemental Life coverage up to the Policy's Guaranteed Issue Limit without evidence provided the request is made within 31 days of the family status change.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Evidence of Insurability (*continued*)

Qualifying events for family status change

1. Change in legal marital status
   - Marriage
   - Death of spouse
   - Divorce
   - Legal separation
   - Annulment
2. Change in the number of dependent children
   - Birth of child
   - Death of child
   - Placement for or finalized adoption
3. Change in employment status (for employee and/or spouse)
   - Commencement or termination of spouse's employment
   - Employee goes from part time to full time
   - Employee goes from full time to part time
   - Employee's job is eliminated

How do I complete an Evidence of Insurability form?

Follow the instructions on the Evidence form, making sure that all the information in Section A (the Plan Sponsor/ Employer) is completed. You must provide the current amount of coverage, the requested increase amount and the resulting total amount of coverage for each individual for whom coverage is being requested. The application will not be processed without the Authorized Representative's signature.

A sample form is shown later in this chapter.

Give the form to the employee for his/her submission to Aetna. Instruct the employee that all the information in Section B (the employee's section) must be completed, signed by the employee and spouse (if dependent coverage is requested) and dated. In order to expedite the processing of the Evidence of Insurability statement, all information on the form must be completed. If any information is missing, Aetna will return the form to the employee to complete the missing information.

When is evidence required for employees who already have coverage?

Subsequent annual benefits election periods allow individuals who already have Life benefits to change coverage options under their Policy, when permitted to do so. Employees can increase their current Life coverage by units or multiples of salary, whichever is applicable, up to the Guaranteed Issue Limit stated in the Policy without Evidence of Insurability. An election that results in insurance amounts in excess of the Guaranteed Issue Level is subject to EOI.

Employees and dependents without current Life coverage who wish to enroll will be subject to late enrollee rules for any amount elected.

Contributory AD&PL coverage does not require Evidence of Insurability to enroll.

Evidence of Insurability reports provided by the Medical Underwriting Department:

You may wish to receive a Customer Report tracking the Evidence of Insurability statements submitted by your employees. This report can be provided in alphabetical order or Social Security order. It will show the date the application was received, who is applying for coverage, the benefit being requested and status of the application (pending, approved, denied, etc.).

You can elect to receive one of two types of reports.

- Weekly reports can be produced. If a weekly report is chosen, no individual letters (that is, approval, denial or pending additional information) will be provided to the customer. The employee will receive requests for additional information and denial letters.
- Monthly reports – If requesting a monthly report, the plan sponsor will receive the report, and both the plan sponsor and the employee will receive individual letters of approval, denial and pending additional information.

Approval letters are mailed to the employer only. An additional cost will apply, per letter, if a copy is mailed to the employee.

Aetna

Evidence of Insurability Statement
Life Coverage
Aetna Life Insurance Company

Read This Instruction Page Carefully.

Aetna may contact you directly to request additional information upon receipt of this completed Statement.

Instructions

Plan Sponsor

Please Print

Complete Section A **in its entirety**. ***Be sure that*:**

- All items are completed.
- **The Control Number, Suffix and Account numbers are provided (A1).**
- The Employee/Member's **Social Security Number** is provided (A2).
  Both the Employee/Member's and your name and address are shown in the spaces provided (A3 and A4).
- The telephone number of your authorized representative (A5), Employee/Member's date of hire (A6) and Employee/Member's home and work telephone numbers (A7) are provided.
- Your Employee/Member's and your E-mail addresses are provided (A8 and A9).
- Employee/Member's Annual Earnings is completed (A10)
  You check the appropriate box(es) for individual(s) requesting Life coverage. Provide the current amount of coverage, requested additional amount of coverage, resulting total amount of coverage and Guarantee Issue amount for each individual for whom coverage is being requested (A11).
- You check the reason for requested life coverage (A11).
- Section A is signed by your Authorized Representative (A12).

Give the form to your Employee/Member for his/her confidential submission to Aetna.

Aetna will advise you of its coverage decision. Employee/Member will be notified directly if coverage is denied.

Employee/Member

Read the Privacy Notice and Misrepresentation section on "Page 2 of 4" of the Insurability Statement before completing.

Please Print

Verify that your name, address and **Social Security Number** as shown in Section A are complete and accurate. We may need to direct additional inquiries to your attention.

Complete Section B. ***Be sure that*:**

- All items are completed.
- Only the names of individuals requesting coverage at this time are listed (B1).
- Height and Weight ***must*** be provided or this form will be returned unprocessed for your completion (B1).
- The appropriate boxes regarding dependent child coverage are checked, if applicable (B2a, B2b, and B2c).
- Complete dates and details are given for all conditions checked in B3g, (B4).
- The form is signed by you. If you are requesting spouse coverage, the spouse's signature is also required. Read the Certification, Acknowledgment and Authorization prior to signing the form (bottom of Section B).

Make a copy for your records. Mail the original to:

Aetna Life Insurance Company
Medical Underwriting Department
P.O Box 83641
Lincoln, NE 68501-3641

OR

Fax to: **1-800-792-9710**

If you have any questions, call us toll-free at:

1-800-660-9913

If a final underwriting decision cannot be made within six months, Aetna reserves the right to request a new Evidence of Insurability Statement.

Please Note: If this form is not completed in its entirety *and* signed, it will be returned unprocessed for your completion.

Privacy Notice

In evaluating your insurability, we (Aetna) will rely primarily on the health information you furnish to us in this Evidence of Insurability Statement. In addition, however, we may ask you to take a physical examination, or request additional medical information about you from any of the sources specified in the authorization on Page 4 of 4 of this form.

Disclosure of Information to Others

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. For example, Aetna Life Insurance Company may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may apply for coverage, or to whom a claim for benefits may be submitted. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding), and to request correction, amendment or deletion of recorded personal information in states which provide such rights and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right, or if you wish to have a more detailed explanation of our information practices, please contact:

Aetna Life Insurance Company, Medical Underwriting Department, 151 Farmington Avenue, Hartford, CT 06156-2975

Under New Mexico law, a resident of New Mexico has the right to register as a "protected person" in connection with disclosure of confidential domestic abuse information. If you wish to exercise this right, write to the address shown above.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially 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.

Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention California, Ohio and Pennsylvania Residents: 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 materially 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.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 materially 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 may subject such person to criminal and civil penalties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents: 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 materially 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Submission and Approval

The requested coverage will not be in effect unless and until evidence of insurability is submitted as required and is approved by Aetna

Aetna

Evidence of Insurability Statement
Life Coverage
Aetna Life Insurance Company

Make a copy for your records. Mail the original to:
Aetna Life Insurance Company
Medical Underwriting Department
P.O. Box 83641
Lincoln, NE 68501-3641
Fax to: 1-800-792-9710
Customer Service: 1-800-660-9913

A. Plan Sponsor: Complete this Section - Please print.

1. Control Number	Suffix	Account	2. Employee/Member Social Security Number
			- -

3. Plan Sponsor Name & Address	4. Employee/Member Name & Address
ATTN:	
Name	
Street	Street
City State ZIP Code	City State ZIP Code

5. Plan Sponsor - Authorized Rep. Telephone Number	6. Employee/Member Date of Hire (MM/DD/YYYY)	7. Employee/Member Telephone Numbers
( ) -		Work ( ) - Home ( ) -

8. Plan Sponsor E-mail address	9. Employee/Member E-mail Address

10. Employee/Member's Annual Earnings $ _____

11. Coverage(s) Applied for:

☐ Life* ☐ Employee/Member Basic Life ☐ Employee/Member Supplemental, Optional or Voluntary Life
☐ Spouse ☐ Child(ren)

	Employee/Member Basic Life	Employee/Member Supplemental, Optional or Voluntary Life	Spouse Life	Child(ren) Life
a. **Current** Amount of Life Insurance Coverage?	$	$	$	$
b. **Additional** Amount of Life Insurance Coverage requested?	$	$	$	$
c. Resulting **Total** Life Insurance Amount if Approved (a + b)?	$	$	$	$
d. **Guarantee Issue** Amount of Life Insurance?	$	$	$	$

***Reason for Requested Coverage (indicate all that apply).**

☐ Salary Increase ☐ Change in Multiple ☐ Late Applicant ☐ Change in Increments ☐ Life Event/Status Change
☐ Requesting an Amount in Excess of Plan's Guaranteed Issue Limit ☐ Other (Please explain) _____

12. I certify the above information is correct.

Plan Sponsor - Authorized Representative Signature | Plan Sponsor - Authorized Representative Name (Please print) | Date Signed

B. Employee/Member: Complete this Section - Please print. ***All questions must be answered. Incomplete forms cannot be processed.***

1. Only the Names of Individual(s) Requesting Coverage at this Time Should be Listed

Name	Relationship	Birthdate (MM/DD/YYYY)	Birthplace (City/State)	Sex	Height (ft., in.)	Weight (lbs.)
Employee:	Self					
Spouse:						
Child(ren):						

2. Complete these questions if dependent children are listed above. ***Use Number 4 if additional space is needed.***

	Yes	No	
a.	☐	☐	Do all dependent children live in your household? If no, please explain: _____
b.	☐	☐	Do all dependent children depend solely on you for support? If no, please explain: _____
c.	☐	☐	If any dependent child is age 19 or older, is/are they regularly attending school? If no, please explain: _____

3. Statement of Health for Individual(s) Listed Above. Please answer the following questions to the best of your knowledge and belief. If any of the following questions are checked "Yes", you must provide details in Number 4 below.

	Yes	No	
a.	☐	☐	Is any individual pregnant? If yes, Who: _____ Date Due: _____ Any complications or problems: _____
b.	☐	☐	Has any individual used tobacco products in the last 12 months (cigarettes, cigar, pipe, chewing tobacco)? If yes, who: _____
c.	☐	☐	Are any inpatient or outpatient medical, surgical or diagnostic procedures recommended or contemplated: If yes, When: _____ Individual: _____ Name of procedure: _____ Reason for procedure: _____
d.	☐	☐	In the past 7 years has any individual been confined to a hospital, clinic, sanatorium, rehabilitation or other treatment facility? If yes, Who: _____ Why: _____ When: _____
e.	☐	☐	In the past 7 years has any individual been examined, monitored or received medical treatment from any doctor, practitioner or counselor for any condition other than minor illnesses (cold, flu, etc.)? If yes, Who: _____ Why: _____ When: _____
f.	☐	☐	Is any individual(s) currently taking medication(s)? If yes, complete the following information:

Name of Individual	Medication	Dosage/Frequency	Diagnosis

g. Within the past 10 years have you, your spouse or child(ren) had any disease, impairment of or treatment (other than minor illnesses) for any of the following? If yes, check the appropriate box(es) and describe in *Number 4*.

☐ AIDS*	☐ Cancer	☐ Immune System Disorder	☐ Nervous System
☐ Arthritis	☐ Carpal Tunnel Syndrome	☐ Intestine/Stomach/Ulcer	☐ Paralysis/Paresis
☐ Asthma/Emphysema/COPD	☐ Chest Pain	☐ Kidney/Bladder	☐ Reproductive System
☐ Back/Spine/Neck	☐ Chronic Fatigue/Fibromyalgia	☐ Liver/Spleen/Pancreas	☐ Skin Disorder
☐ Blood Disorder/Bleeding/Blood Clot	☐ Diabetes/Metabolic	☐ Lungs/Breathing	☐ Stroke
☐ Blood Pressure/Hypertension	☐ Ears/Eyes	☐ Lupus	☐ Substance Abuse (Alcohol/Drug)
☐ Blood Vessels/Circulation	☐ Epilepsy/Seizure	☐ Mental/Emotional Condition	☐ Throat/Tonsils/Swallowing
☐ Bones/Joints	☐ Esophagus/Digestion/GERD	☐ Multiple Sclerosis	☐ Thyroid/Pituitary/Adrenal
☐ Brain	☐ Heart	☐ Muscular Condition	☐ Tumor/Growth

☐ **Other** _____

*AIDS (Acquired Immune Deficiency Syndrome) is a serious disease. It is caused by a virus called HIV (Human Immunodeficiency Virus). The virus is found in some human body fluids of infected people, most notably in semen and blood. If the AIDS virus finds its way into the bloodstream, it can damage the body's defenses against disease, resulting in life-threatening diseases. There is no known cure.

4. In the space below, describe all conditions checked in 3g above and provide additional information for questions 2a-c and 3a-f, if needed.

Ques. No.	Name Of Individual	Diagnosis	Date of Onset	Details/ Symptoms	Treatments Received	Full Recovery Date

☐ *Check here if you are providing additional information on a separate attachment.*

Certification: I certify these answers and statements are complete and true to the best of my knowledge and belief. I will inform Aetna of any material changes to the information provided which take place between the time the form is completed and the time coverage becomes effective. I agree that this document shall become a part of my request for group coverage and I acknowledge that I have retained a copy of this document as completed by me.

Acknowledgment: I understand that, to the extent permitted by state law, false statements may result in the denial of claims or in my insurance coverage being void as of its effective date with no benefits payable. I understand that conditions which are disclosed on this form may be subject to all conditions of my Plan Sponsor's Plan including any preexisting condition limitations, fraud provisions and employee actively at work and dependent health condition requirements. My signature indicates that I have reviewed all information and statements on this form for completeness and accuracy.

Authorization: To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical or hospital service and prepaid health plans, employers and the Medical Information Bureau: You are authorized to provide Aetna Life Insurance Company (Aetna) information concerning healthcare, advice, treatment or supplies (including those related to mental illness and/or AIDS/ARC/HIV) provided me or any members of my family for whom coverage has been requested. (Minnesota residents are not required to provide information concerning results of AIDS/ARC/HIV tests performed on a criminal offender or a crime victim.) I acknowledge that information obtained from any or all of the above may result in further underwriting investigation. This information will be used for the purpose of determining eligibility for coverage. This authorization will be valid for twelve (12) months from the date signed. **I acknowledge that I have read the Privacy Notice and Misrepresentation section shown on "Page 2 of 4" of this form and know that I have a right to receive a copy of this authorization upon request.** I agree that a photographic copy of this authorization is as valid as the original.

Employee/Member's or Authorized Person's Signature (*Required at all times*)	Date	Spouse's or Authorized Person's Signature (Required if spouse coverage is requested)	Date

Evidence of Insurability Statement
Life and Disability Coverage

Aetna Life Insurance Company

Read This Instruction Page Carefully.

Aetna may contact you directly to request additional information upon receipt of this completed Statement.

Instructions

Plan Sponsor

Please Print

Complete Section A **in its entirety**. ***Be sure that*:**

- All items are completed.
- **The Control Number, Suffix and Account numbers are provided (A1).**
- The Employee/Member's **Social Security Number** is provided (A2).
- Both the Employee/Member's and your name and address are shown in the spaces provided (A3 and A4).
- The telephone number of your authorized representative (A5), Employee/Member's date of hire (A6) and Employee/Member's home and work telephone numbers (A7) are provided.
- Your Employee/Member's and your E-mail addresses are provided (A8 and A9).
- Employee/Member's Annual Earnings is completed (A10)
- You check the appropriate box(es) for individual(s) requesting Life coverage. Provide the current amount of coverage, requested additional amount of coverage, resulting total amount of coverage and Guarantee Issue amount for each individual for whom coverage is being requested (A11).
- You check the reason for requested life coverage (A11).
- You check the appropriate Disability box(es) and provide current and requested amounts of coverage (A11).
- Section A is signed by your Authorized Representative (A12).

Give the form to your Employee/Member for his/her confidential submission to Aetna.
Aetna will advise you of its coverage decision. Employee/Member will be notified directly if coverage is denied.

Employee/Member

Read the Privacy Notice and Misrepresentation section on "Page 2 of 4" of the Insurability Statement before completing.

Please Print

Verify that your name, address and **Social Security Number** as shown in Section A are complete and accurate. We may need to direct additional inquiries to your attention.

Complete Section B. ***Be sure that*:**

- All items are completed.
- Only the names of individuals requesting coverage at this time are listed (B1).
- Height and Weight ***must*** be provided or this form will be returned unprocessed for your completion (B1).
- The appropriate boxes regarding dependent child coverage are checked, if applicable (B2a, B2b, and B2c).
- Complete dates and details are given for all conditions checked in B3g, (B4).
- The form is signed by you. If you are requesting spouse coverage, the spouse's signature is also required. Read the Certification, Acknowledgment and Authorization prior to signing the form (bottom of Section B).

Make a copy for your records. Mail the original to:

Aetna Life Insurance Company
Medical Underwriting Department
P.O Box 83641
Lincoln, NE 68501-3641

OR

Fax to: **1-800-792-9710**

If you have any questions, call us toll-free at:

1-800-660-9913

If a final underwriting decision cannot be made within six months, Aetna reserves the right to request a new Evidence of Insurability Statement.

Please Note: If this form is not completed in its entirety *and* signed, it will be returned unprocessed for your completion.

Privacy Notice

In evaluating your insurability, we (Aetna) will rely primarily on the health information you furnish to us in this Evidence of Insurability Statement. In addition, however, we may ask you to take a physical examination, or request additional medical information about you from any of the sources specified in the authorization on Page 4 of 4 of this form.

Disclosure of Information to Others

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. For example, Aetna Life Insurance Company may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may apply for coverage, or to whom a claim for benefits may be submitted. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding), and to request correction, amendment or deletion of recorded personal information in states which provide such rights and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right, or if you wish to have a more detailed explanation of our information practices, please contact:

Aetna Life Insurance Company, Medical Underwriting Department, 151 Farmington Avenue, Hartford, CT 06156-2975

Under New Mexico law, a resident of New Mexico has the right to register as a "protected person" in connection with disclosure of confidential domestic abuse information. If you wish to exercise this right, write to the address shown above.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially 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.

Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention California, Ohio and Pennsylvania Residents: 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 materially 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.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 materially 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 may subject such person to criminal and civil penalties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents: 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 materially 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Submission and Approval

The requested coverage will not be in effect unless and until evidence of insurability is submitted as required and is approved by Aetna.

Aetna

Evidence of Insurability Statement
Life and Disability Coverage
Aetna Life Insurance Company

Make a copy for your records. Mail the original to:
Aetna Life Insurance Company
Medical Underwriting Department
P.O. Box 83641
Lincoln, NE 68501-3641
Fax to: 1-800-792-9710
Customer Service: 1-800-660-9913

A. Plan Sponsor: Complete this Section - Please print.

1. Control Number / Suffix / Account	2. Employee/Member Social Security Number
	– –
3. Plan Sponsor Name & Address ATTN: Name Street City State ZIP Code	4. Employee/Member Name & Address Street City State ZIP Code
5. Plan Sponsor - Authorized Rep. Telephone Number ( ) –	6. Employee/Member Date of Hire (MM/DD/YYYY)
7. Employee/Member Telephone Numbers Work ( ) – Home ( ) –	
8. Plan Sponsor E-mail address	9. Employee/Member E-mail Address

10. Employee/Member's Annual Earnings $ _____

11. Coverage(s) Applied for

☐ Life* ☐ Employee/Member Basic Life ☐ Employee/Member Supplemental, Optional or Voluntary Life
☐ Spouse ☐ Child(ren)

	Employee/Member Basic Life	Employee/Member Supplemental, Optional or Voluntary Life	Spouse Life	Child(ren) Life
a. **Current** Amount of Life Insurance Coverage?	$ _____	$ _____	$ _____	$ _____
b. **Additional** Amount of Life Insurance Coverage requested?	$ _____	$ _____	$ _____	$ _____
c. Resulting **Total** Life Insurance Amount if Approved (a + b)?	$ _____	$ _____	$ _____	$ _____
d. **Guarantee Issue** Amount of Life Insurance?	$ _____	$ _____	$ _____	$ _____

***Reason for Requested Coverage (indicate all that apply).**

☐ Salary Increase ☐ Change in Multiple ☐ Late Applicant ☐ Change in Increments ☐ Life Event/Status Change
☐ Requesting an Amount in Excess of Plan's Guaranteed Issue Limit ☐ Other (Please explain) _____

Disability Coverages (Employee/Member Only):

☐ **Short Term Disability**: Current Amount $ _____ or _____ % Requested Amount $ _____ or _____ %
☐ **Long Term Disability**: Current Amount $ _____ or _____ % Requested Amount $ _____ or _____ %

12. I certify the above information is correct.

Plan Sponsor - Authorized Representative Signature | Plan Sponsor - Authorized Representative Name (Please print) | Date Signed

B. Employee/Member: Complete this Section - Please print. ***All questions must be answered. Incomplete forms cannot be processed.***

1. Only the Names of Individual(s) Requesting Coverage at this Time Should be Listed

Name	Relationship	Birthdate *(MM/DD/YYYY)*	Birthplace (City/State)	Sex	Height (ft., in.)	Weight (lbs.)
Employee:	Self					
Spouse:						
Child(ren):						

2. Complete these questions if dependent children are listed above. ***Use Number 4 if additional space is needed.***

	Yes	No	
a.	☐	☐	Do all dependent children live in your household? If no, please explain: _____
b.	☐	☐	Do all dependent children depend solely on you for support? If no, please explain: _____
c.	☐	☐	If any dependent child is age 19 or older, is/are they regularly attending school? If no, please explain: _____

3. Statement of Health for Individual(s) Listed Above. Please answer the following questions to the best of your knowledge and belief. If any of the following questions are checked "Yes", you must provide details in Number 4 below.

	Yes	No	
a.	☐	☐	Is any individual pregnant? If yes, Who:_____Date Due: _____ Any complications or problems: _____
b.	☐	☐	Has any individual used tobacco products in the last 12 months (cigarettes, cigar, pipe, chewing tobacco)? If yes, who: _____
c.	☐	☐	Are any inpatient or outpatient medical, surgical or diagnostic procedures recommended or contemplated: If yes, When: _____ Individual: _____ Name of procedure: _____ Reason for procedure: _____
d.	☐	☐	In the past 7 years has any individual been confined to a hospital, clinic, sanatorium, rehabilitation or other treatment facility? If yes, Who: _____ Why: _____ When: _____
e.	☐	☐	In the past 7 years has any individual been examined, monitored or received medical treatment from any doctor, practitioner or counselor for any condition other than minor illnesses (cold, flu, etc.)? If yes, Who: _____ Why: _____ When: _____
f.	☐	☐	Is any individual(s) currently taking medication(s)? If yes, complete the following information:

Name of Individual	Medication	Dosage/Frequency	Diagnosis

g. Within the past 10 years have you, your spouse or child(ren) had any disease, impairment of or treatment (other than minor illnesses) for any of the following? If yes, check the appropriate box(es) and describe in *Number 4*.

☐ AIDS*	☐ Cancer	☐ Immune System Disorder	☐ Nervous System
☐ Arthritis	☐ Carpal Tunnel Syndrome	☐ Intestine/Stomach/Ulcer	☐ Paralysis/Paresis
☐ Asthma/Emphysema/COPD	☐ Chest Pain	☐ Kidney/Bladder	☐ Reproductive System
☐ Back/Spine/Neck	☐ Chronic Fatigue/Fibromyalgia	☐ Liver/Spleen/Pancreas	☐ Skin Disorder
☐ Blood Disorder/Bleeding/Blood Clot	☐ Diabetes/Metabolic	☐ Lungs/Breathing	☐ Stroke
☐ Blood Pressure/Hypertension	☐ Ears/Eyes	☐ Lupus	☐ Substance Abuse (Alcohol/Drug)
☐ Blood Vessels/Circulation	☐ Epilepsy/Seizure	☐ Mental/Emotional Condition	☐ Throat/Tonsils/Swallowing
☐ Bones/Joints	☐ Esophagus/Digestion/GERD	☐ Multiple Sclerosis	☐ Thyroid/Pituitary/Adrenal
☐ Brain	☐ Heart	☐ Muscular Condition	☐ Tumor/Growth

☐ **Other** _____

*AIDS (Acquired Immune Deficiency Syndrome) is a serious disease. It is caused by a virus called HIV (Human Immunodeficiency Virus). The virus is found in some human body fluids of infected people, most notably in semen and blood. If the AIDS virus finds its way into the bloodstream, it can damage the body's defenses against disease, resulting in life-threatening diseases. There is no known cure.

4. In the space below, describe all conditions checked in 3g above and provide additional information for questions 2a-c and 3a-f, if needed.

Ques. No.	Name Of Individual	Diagnosis	Date of Onset	Details/ Symptoms	Treatments Received	Full Recovery Date

☐ *Check here if you are providing additional information on a separate attachment.*

Certification: I certify these answers and statements are complete and true to the best of my knowledge and belief. I will inform Aetna of any material changes to the information provided which take place between the time the form is completed and the time coverage becomes effective. I agree that this document shall become a part of my request for group coverage and I acknowledge that I have retained a copy of this document as completed by me.

Acknowledgment: I understand that, to the extent permitted by state law, false statements may result in the denial of claims or in my insurance coverage being void as of its effective date with no benefits payable. I understand that conditions which are disclosed on this form may be subject to all conditions of my Plan Sponsor's Plan including any preexisting condition limitations, fraud provisions and employee actively at work and dependent health condition requirements. My signature indicates that I have reviewed all information and statements on this form for completeness and accuracy.

Authorization: To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical or hospital service and prepaid health plans, employers and the Medical Information Bureau: You are authorized to provide Aetna Life Insurance Company (Aetna) information concerning healthcare, advice, treatment or supplies (including those related to mental illness and/or AIDS/ARC/HIV) provided me or any members of my family for whom coverage has been requested. (Minnesota residents are not required to provide information concerning results of AIDS/ARC/HIV tests performed on a criminal offender or a crime victim.) I acknowledge that information obtained from any or all of the above may result in further underwriting investigation. This information will be used for the purpose of determining eligibility for coverage. This authorization will be valid for twelve (12) months from the date signed. **I acknowledge that I have read the Privacy Notice and Misrepresentation section shown on "Page 2 of 4" of this form and know that I have a right to receive a copy of this authorization upon request.** I agree that a photographic copy of this authorization is as valid as the original.

Employee/Member's or Authorized Person's Signature (*Required at all times*)	Date	Spouse's or Authorized Person's Signature (Required if spouse coverage is requested)	Date

Page 4 of 4

Evidence of Insurability Statement
Disability Coverage
Aetna Life Insurance Company

Read This Instruction Page Carefully.

Aetna may contact you directly to request additional information upon receipt of this completed Statement.

Instructions

Plan Sponsor

Please Print

Complete Section A **in its entirety**. ***Be sure that:***

- All items are completed.
- **The Control Number, Suffix and Account numbers are provided (A1).**
- The Employee/Member's **Social Security Number** is provided (A2).
- Both the Employee/Member's and your name and address are shown in the spaces provided (A3 and A4).
- The telephone number of your authorized representative (A5), Employee/Member's date of hire (A6) and Employee/Member's home and work telephone numbers (A7) are provided.
- Your Employee/Member's and your E-mail addresses are provided (A8 and A9).
- Employee/Member's Annual Earnings is completed (A10)
- You check the appropriate Disability box(es) and provide current and requested amounts of coverage (A11).
- Section A is signed by your Authorized Representative (A12).

Give the form to your Employee/Member for his/her confidential submission to Aetna.

Aetna will advise you of its coverage decision. Employee/Member will be notified directly if coverage is denied.

Employee/Member

Read the Privacy Notice and Misrepresentation section on "Page 2 of 4" of the Insurability Statement before completing.

Please Print

Verify that your name, address and **Social Security Number** as shown in Section A are complete and accurate. We may need to direct additional inquiries to your attention.

Complete Section B. ***Be sure that:***

- All items are completed.
- Birthdate, Sex, Height and Weight are completed (B1).
- Height and Weight ***must*** be provided or this form will be returned unprocessed for your completion (B1).
- Complete dates and details are given for all conditions checked in B2g, (B3).
- The form is signed by you. Read the Certification, Acknowledgment and Authorization prior to signing the form (bottom of Section B).

Make a copy for your records. Mail the original to:

Aetna Life Insurance Company
Medical Underwriting Department
P.O Box 83641
Lincoln, NE 68501-3641

OR

Fax to: **1-800-792-9710**

If you have any questions, call us toll-free at:

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If a final underwriting decision cannot be made within six months, Aetna reserves the right to request a new Evidence of Insurability Statement.

Please Note: If this form is not completed in its entirety *and* signed, it will be returned unprocessed for your completion.

Evidence of Insurability Statement – Disability Coverage

Privacy Notice

In evaluating your insurability, we (Aetna) will rely primarily on the health information you furnish to us in this Evidence of Insurability Statement. In addition, however, we may ask you to take a physical examination, or request additional medical information about you from any of the sources specified in the authorization on Page 4 of 4 of this form.

Disclosure of Information to Others

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Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding), and to request correction, amendment or deletion of recorded personal information in states which provide such rights and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right, or if you wish to have a more detailed explanation of our information practices, please contact:

Aetna Life Insurance Company, Medical Underwriting Department, 151 Farmington Avenue, Hartford, CT 06156-2975

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Misrepresentation

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Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 materially 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 may subject such person to criminal and civil penalties.

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Attention New York Residents: 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 materially 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Submission and Approval

The requested coverage will not be in effect unless and until evidence of insurability is submitted as required and is approved by Aetna

Aetna

Evidence of Insurability Statement
Disability Coverage
Aetna Life Insurance Company

Make a copy for your records. Mail the original to:
Aetna Life Insurance Company
Medical Underwriting Department
P.O. Box 83641
Lincoln, NE 68501-3641
Fax to: 1-800-792-9710
Customer Service: 1-800-660-9913

A. Plan Sponsor: Complete this Section - Please print.

1. Control Number / Suffix / Account	2. Employee/Member Social Security Number
	- -
3. Plan Sponsor Name & Address ATTN: Name Street City State ZIP Code	4. Employee/Member Name & Address Street City State ZIP Code
5. Plan Sponsor - Authorized Rep. Telephone Number ( ) -	6. Employee/Member Date of Hire (MM/DD/YYYY)
	7. Employee/Member Telephone Numbers Work ( ) - Home ( ) -
8. Plan Sponsor E-mail address	9. Employee/Member E-mail Address

10. Employee/Member's Annual Earnings $ _____

11. Coverage(s) Applied for

Disability Coverages (Employee/Member Only):

☐ **Short Term Disability**: Current Amount $ _____ or _____ % Requested Amount $ _____ or _____ %

☐ **Long Term Disability**: Current Amount $ _____ or _____ % Requested Amount $ _____ or _____ %

12. I certify the above information is correct.

Plan Sponsor - Authorized Representative Signature | Plan Sponsor - Authorized Representative Name (Please print) | Date Signed

B. Employee/Member: Complete this Section - Please print. *All questions must be answered. Incomplete forms cannot be processed.*

1.	Birthdate (MM/DD/YYYY)	Sex ☐ M ☐ F	Height (ft., in.)	Weight (lbs.)

2. Statement of Health for Individual listed above. Please answer the following questions to the best of your knowledge and belief. If any of the following questions are checked "Yes", you must provide details in Number 3 below.

	Yes	No	
a.	☐	☐	If female are you pregnant? If yes, Date Due: _____ Any complications or problems: _____
b.	☐	☐	Have you used tobacco products in the last 12 months (cigarettes, cigar, pipe, chewing tobacco)?
c.	☐	☐	Are any inpatient or outpatient medical, surgical or diagnostic procedures recommended or contemplated: If yes, When: _____ Name of procedure: _____ Reason for procedure: _____
d.	☐	☐	In the past 7 years have you been confined to a hospital, clinic, sanatorium, rehabilitation or other treatment facility? If yes, Why: _____ When: _____
e.	☐	☐	In the past 7 years have you been examined, monitored or received medical treatment from any doctor, practitioner or counselor for any condition other than minor illnesses (cold, flu, etc.)? If yes, Why: _____ When: _____
f.	☐	☐	Are you currently taking medication(s)? If yes, complete the following information:

Medication	Dosage/Frequency	Diagnosis

g. Within the past 10 years have you had any disease, impairment of or treatment (other than minor illnesses) for any of the following? If yes, check the appropriate box(es) and describe in *Number 3*.

☐ AIDS*	☐ Cancer	☐ Immune System Disorder	☐ Nervous System
☐ Arthritis	☐ Carpal Tunnel Syndrome	☐ Intestine/Stomach/Ulcer	☐ Paralysis/Paresis
☐ Asthma/Emphysema/COPD	☐ Chest Pain	☐ Kidney/Bladder	☐ Reproductive System
☐ Back/Spine/Neck	☐ Chronic Fatigue/Fibromyalgia	☐ Liver/Spleen/Pancreas	☐ Skin Disorder
☐ Blood Disorder/Bleeding/Blood Clot	☐ Diabetes/Metabolic	☐ Lungs/Breathing	☐ Stroke
☐ Blood Pressure/Hypertension	☐ Ears/Eyes	☐ Lupus	☐ Substance Abuse (Alcohol/Drug)
☐ Blood Vessels/Circulation	☐ Epilepsy/Seizure	☐ Mental/Emotional Condition	☐ Throat/Tonsils/Swallowing
☐ Bones/Joints	☐ Esophagus/Digestion/GERD	☐ Multiple Sclerosis	☐ Thyroid/Pituitary/Adrenal
☐ Brain	☐ Heart	☐ Muscular Condition	☐ Tumor/Growth

☐ **Other** _____

*AIDS (Acquired Immune Deficiency Syndrome) is a serious disease. It is caused by a virus called HIV (Human Immunodeficiency Virus). The virus is found in some human body fluids of infected people, most notably in semen and blood. If the AIDS virus finds its way into the bloodstream, it can damage the body's defenses against disease, resulting in life-threatening diseases. There is no known cure.

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Evidence of Insurability Statement – Disability Coverage

3.	In the space below, describe all conditions checked in 2g above and provide additional information for questions 2a-f, if needed.				
Ques. No.	Diagnosis	Date of Onset	Details/ Symptoms	Treatments Received	Full Recovery Date

☐ *Check here if you are providing additional information on a separate attachment.*

Certification: I certify these answers and statements are complete and true to the best of my knowledge and belief. I will inform Aetna of any material changes to the information provided which take place between the time the form is completed and the time coverage becomes effective. I agree that this document shall become a part of my request for group coverage and I acknowledge that I have retained a copy of this document as completed by me.

Acknowledgment: I understand that, to the extent permitted by state law, false statements may result in the denial of claims or in my insurance coverage being void as of its effective date with no benefits payable. I understand that conditions which are disclosed on this form may be subject to all conditions of my Plan Sponsor's Plan including any preexisting condition limitations, fraud provisions and employee actively at work and dependent health condition requirements. My signature indicates that I have reviewed all information and statements on this form for completeness and accuracy.

Authorization: To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical or hospital service and prepaid health plans, employers and the Medical Information Bureau: You are authorized to provide Aetna Life Insurance Company (Aetna) information concerning healthcare, advice, treatment or supplies (including those related to mental illness and/or AIDS/ARC/HIV) provided me or any members of my family for whom coverage has been requested. (Minnesota residents are not required to provide information concerning results of AIDS/ARC/HIV tests performed on a criminal offender or a crime victim.) I acknowledge that information obtained from any or all of the above may result in further underwriting investigation. This information will be used for the purpose of determining eligibility for coverage. This authorization will be valid for twelve (12) months from the date signed. **I acknowledge that I have read the Privacy Notice and Misrepresentation section shown on "Page 2 of 4" of this form and know that I have a right to receive a copy of this authorization upon request.** I agree that a photographic copy of this authorization is as valid as the original.

Employee/Member's or Authorized Person's Signature (*Required at all times*)	Date

Page 4 of 4

Evidence of Insurability Statement – Group Universal Life Coverage

Aetna

Evidence of Insurability Statement
Group Universal Life Coverage
Aetna Life Insurance Company

Read This Instruction Page Carefully.

Aetna may contact you directly to request additional information upon receipt of this completed Statement.

Instructions

Employee/Member

Read the Privacy Notice and Misrepresentation section on "Page 2 of 4" of the Insurability Statement before completing.

Please Print

Complete Section A **in its entirety**. ***Be sure that*:**

- All items are completed.
- **The Control Number, Suffix and Account numbers are provided (A1).**
- Your **Social Security Number** is provided (A2).*
- Both the employer's and your name and address are shown in the spaces provided (A3 and A4).*
- The telephone number of your authorized representative (if available - A5), your date of hire (A6) and your home and work telephone numbers (A7) are provided.
- You check the appropriate box(es) for individual(s) requesting coverage. Provide the current amount of coverage, requested additional amount of coverage and resulting total amount of coverage for each individual for whom coverage is being requested (A8).
- You provide the reason for requested coverage and your Annual Earnings (A9).

Complete Section B. ***Be sure that*:**

- All items are completed.
- Only the names of individuals requesting coverage at this time are listed (B1).
- Height and Weight ***must*** be provided or this form will be returned unprocessed for your completion (B1).
- The appropriate boxes regarding dependent child coverage are checked, if applicable (B2a, B2b, and B2c).
- Complete dates and details are given for all conditions checked in B3g (B4).
- The form is signed by you. If you are requesting spouse coverage, the spouse's signature is also required. Read the Certification, Acknowledgment and Authorization prior to signing the form (bottom of Section B).

Make a copy for your records. Mail the original to:

Aetna Life Insurance Company
Medical Underwriting Department
P.O. Box 83641
Lincoln, NE 68501-3641

OR

Fax to: **1-800-792-9710**

If you have any questions, call us at:
1-800-660-9913

*Verify that your name, address and **Social Security Number** as shown in Section A are complete and accurate. We may need to direct additional inquiries to your attention.

Aetna will advise your employer of its coverage decision. You will be notified directly if coverage is denied.

If a final underwriting decision cannot be made within six months, Aetna reserves the right to request a new Evidence of Insurability Statement.

Please Note: If this form is not completed in its entirety *and* signed, it will be returned unprocessed for your completion.

Evidence of Insurability Statement – Group Universal Life Coverage

Privacy Notice

In evaluating your insurability, we (Aetna) will rely primarily on the health information you furnish to us in this Evidence of Insurability Statement. In addition, however, we may ask you to take a physical examination, or request additional medical information about you from any of the sources specified in the authorization on Page 4 of 4 of this form.

Disclosure of Information to Others

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. For example, Aetna Life Insurance Company may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may apply for coverage, or to whom a claim for benefits may be submitted. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding), and to request correction, amendment or deletion of recorded personal information in states which provide such rights and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right, or if you wish to have a more detailed explanation of our information practices, please contact:

Aetna Life Insurance Company
Medical Underwriting Department
151 Farmington Avenue
Hartford, CT 06156-2975

Under New Mexico law, a resident of New Mexico has the right to register as a "protected person" in connection with disclosure of confidential domestic abuse information. If you wish to exercise this right, write to the address shown above.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially 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.

Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention California, Ohio and Pennsylvania Residents: 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 materially 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.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 materially 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 may subject such person to criminal and civil penalties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Submission and Approval

The requested coverage will not be in effect unless and until evidence of insurability is submitted as required and is approved by Aetna.

Aetna

Evidence of Insurability Statement
Group Universal Life Coverage
Aetna Life Insurance Company

Make a copy for your records. Mail the original to:

Aetna Life Insurance Company
Medical Underwriting Department
P.O. Box 83641
Lincoln, NE 68501-3641
Fax to: 1-800-792-9710
Customer Service: 1-800-660-9913

A. Employee/Member: Complete this Section - Please print.

1. Control Number / Suffix / Account	2. Employee/Member Social Security Number
	- -

3. Plan Sponsor/Employer Name & Address	4. Employee/Member Name & Address
ATTN:	
Name	
Street	Street
City / State / ZIP Code	City / State / ZIP Code

5. Plan Sponsor - Authorized Rep Telephone Number	6. Employee/Member Date of Hire (MM-DD-YY)	7. Employee/Member Telephone Numbers
( ) -		Work ( ) - Home ( ) -

8. **Life Coverage Applied for:** ☐ Employee/Member ☐ Spouse ☐ Child(ren)

	Employee	Spouse	Child(ren)
a. **Current or Guarantee Issue** Amount of Life Insurance Coverage?	$	$	$
b. **Additional** Amount of Life Insurance Coverage requested?	$	$	$
c. Resulting **Total** Life Insurance Amount if Approved (a + b)?	$	$	$

9. **Reason for Requested Coverage (indicate all that apply).**

☐ Salary Increase ☐ Change in Multiple ☐ Late Applicant ☐ Change in Increments ☐ Life Event/Status Change
☐ Requesting an Amount in Excess of Plan's Guaranteed Issue Limit ☐ Other (Please explain) _____

Employee/Member's Annual Earnings: $ _____

B. Employee/Member: Complete this Section - Please print. *All questions must be answered. Incomplete forms cannot be processed.*

1. Only the Names of Individual(s) Requesting Coverage at this Time Should be Listed

Name	Relationship	Birthdate (MM/DD/YYYY)	Sex	Height (ft., in.)	Weight (lbs.)
Employee/Member:	Self				
Spouse:					
Child(ren):					

2. Complete these questions if dependent children are listed above. ***Use Number 4 if additional space is needed.***

	Yes	No	
a.	☐	☐	Do all dependent children live in your household? If no, please explain: _____
b.	☐	☐	Do all dependent children depend solely on you for support? If no, please explain: _____
c.	☐	☐	If any dependent child is age 19 or older, is/are they regularly attending school? If no, please explain: _____

3. Statement of Health for Individual(s) Listed Above. Please answer the following questions to the best of your knowledge and belief. If any of the following questions are checked "Yes", you must provide details in Number 4 below.

	Yes	No	
a.	☐	☐	Is any individual pregnant: If yes, Who: _____ Due Date: _____ Any complications or problems: _____
b.	☐	☐	Has any individual used tobacco products in the last 12 months (cigarettes, cigar, pipe, chewing tobacco)? If yes, who: _____
c.	☐	☐	Are any inpatient or outpatient medical, surgical or diagnostic procedures recommended or contemplated? If yes, When. _____
			Individual: _____ Name of procedure: _____ Reason for procedure: _____

B. Employee/Member: Complete this Section (Continued) - Please print.

3. Statement of Health - Continued. ***Use Number 4 if additional space is needed.***

	Yes	No	
d.	☐	☐	In the past 5 years has any individual been confined to a hospital, clinic, sanatorium, rehabilitation or other treatment facility? If yes, Who: _____ Why: _____ When: _____
e.	☐	☐	In the past 5 years has any individual been examined by, consulted with, or received medical treatment from any physician or practitioner for any condition other than minor illnesses (cold, flu, etc.)? If yes, Who: _____ Why: _____ When: _____
f.	☐	☐	Is any individual(s) currently taking medication(s)? If yes, complete the following information:

Name of Individual	Medication	Dosage/Frequency	Diagnosis

g. Within the past 10 years have you or your spouse or child(ren) had any disease, impairment of or treatment (other than minor illnesses) for any of the following?
If yes, check the appropriate box(es) and describe in *Number 4*.

☐ AIDS*	☐ Cancer	☐ Immune System Disorder	☐ Nervous System
☐ Arthritis	☐ Carpal Tunnel Syndrome	☐ Intestine/Stomach/Ulcer	☐ Paralysis/Paresis
☐ Asthma/Emphysema/COPD	☐ Chest Pain	☐ Kidney/Bladder	☐ Reproductive System
☐ Back/Spine/Neck	☐ Chronic Fatigue/Fibromyalgia	☐ Liver/Spleen/Pancreas	☐ Skin Disorder
☐ Blood Disorder/Bleeding/Blood Clot	☐ Diabetes/Metabolic	☐ Lungs/Breathing	☐ Stroke
☐ Blood Pressure/Hypertension	☐ Ears/Eyes	☐ Lupus	☐ Substance Abuse (Alcohol/Drug)
☐ Blood Vessels/Circulation	☐ Epilepsy/Seizure	☐ Mental/Emotional Condition	☐ Throat/Tonsils/Swallowing
☐ Bones/Joints	☐ Esophagus/Digestion/GERD	☐ Multiple Sclerosis	☐ Thyroid/Pituitary/Adrenal
☐ Brain	☐ Heart	☐ Muscular Condition	☐ Tumor/Growth

☐ **Other** _____

*AIDS (Acquired Immune Deficiency Syndrome) is a serious disease. It is caused by a virus called HIV (Human Immunodeficiency Virus). The virus is found in some human body fluids of infected people, most notably in semen and blood. If the AIDS virus finds its way into the bloodstream, it can damage the body's defenses against disease, resulting in life-threatening diseases. There is no known cure.

4. In the space below, describe all conditions checked in question 3g above and provide additional information for questions 2a-c and 3a-f, if needed.

Ques. No.	Name of Individual	Diagnosis	Date of Onset	Details/ Symptoms	Treatment(s) Received	Full Recovery Date

☐ *Check here if you are providing additional information on a separate attachment.*

Certification: I certify these answers and statements are complete and true to the best of my knowledge and belief. I will inform Aetna of any material changes to the information provided which take place between the time the form is completed and the time coverage becomes effective. I agree that this document shall become a part of my request for group coverage and I acknowledge that I have retained a copy of this document as completed by me.

Acknowledgment: I understand that, to the extent permitted by state law, false statements may result in the denial of claims or in my insurance coverage being void as of its effective date with no benefits payable. I understand that conditions which are disclosed on this form may be subject to all conditions of my employer's Plan including any preexisting condition limitations, fraud provisions and employee actively at work and dependent health condition requirements. My signature indicates that I have reviewed all information and statements on this form for completeness and accuracy.

Authorization: To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical or hospital service and prepaid health plans, employers and the Medical Information Bureau: You are authorized to provide Aetna Life Insurance Company (Aetna) information concerning healthcare, advice, treatment or supplies (including those related to mental illness and/or AIDS/ARC/HIV) provided me or any members of my family for whom coverage has been requested. (Minnesota residents are not required to provide information concerning results of AIDS/ARC/HIV tests performed on a criminal offender or a crime victim.) I acknowledge that information obtained from any or all of the above may result in further underwriting investigation. This information will be used for the purpose of determining eligibility for coverage. This authorization will be valid for thirty (12) months from the date signed. **I acknowledge that I have read the Privacy Notice and Misrepresentation section shown on "Page 2 of 4" of this form and know that I have a right to receive a copy of this authorization upon request.** I agree that a photographic copy of this authorization is as valid as the original.

Employee's or Authorized Person's Signature (*Required at all times*)	Date	Spouse's or Authorized Person's Signature (*Required if spouse coverage is requested.*)	Date

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If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Premium Waiver

Premium Waiver – disability claims

Premium Waiver for permanently and totally disabled employees

If your Life Insurance benefit includes a Premium Waiver (PW) provision, an employee who is not able to work due to a permanent and total disability will be eligible to have his/her Life Insurance extended, without premium payments, provided his/her claim for Premium Waiver extension is approved by Aetna.

An employee must meet the following conditions to be eligible:

- Life Insurance must be in force for the employee when the employee becomes totally disabled; and
- The employee leaves work due to disease or injury that causes the total disability before reaching a specific age as stated in the policy (usually 60); and
- The permanent and total disability must last for at least the number of months indicated in the policy; and
- The employee must give Aetna any proof to support the claim when requested during the first two years after the PW was approved. After that, the employee must give Aetna proof once a year.

Some policies do vary, so be careful to check your Group Policy for the specific terms that apply to your Group Policy.

If an employee is eligible for PW benefits, a notice of the claim must be submitted to Aetna no later than the filing limit indicated in the Policy. Notice received outside of this timeframe will be treated as late and the claim will be denied without further consideration.

If the employee is not eligible for PW benefits (for example, the employee was over the age limit, not disabled or filed late), please refer to "Disabilities – General Information," which appears later in this chapter.

Non-Premium Waiver – disability claims

If your Group Policy does not include a PW provision and Aetna has agreed to investigate claims for total disability on your company's behalf (for example, Death Benefit Only/Aetna Investigates Disability, referred to as DBO/AID), an employee who is not able to work due to a permanent and total disability will be eligible to have his/her Life Insurance extended, **subject to continued premium payments,** provided the disability claim is approved by Aetna.

Similar to the Premium Waiver provision discussed before, Life Insurance must be in force for the employee when the employee becomes totally disabled; the permanent and total disability must last for at least the number of months indicated in the Policy; the disease or injury that causes the total disability must begin prior to the specific age limit (usually 60); and, the employee must furnish Aetna any proof to support the claim when requested during the first two years after the claim was approved. Thereafter, the employee must furnish Aetna with such proof once a year.

Again, some policies do vary, so be careful to check your Group Policy for the specific terms that apply to your Group Policy.

If an employee becomes disabled, a Life Insurance Continuation form must be submitted to Aetna no later than the timely filing limit indicated in the Policy. A Life Insurance Continuation form received outside of this timeframe will be treated as late and will be denied without further consideration.

If the employee is not eligible (for example, the employee was over the age limit, not disabled or did not file in a timely manner), please refer to "Disabilities – General Information."

If the Aetna Policy terminates, then coverage ceases for anyone on disability extension.

Note: If your Group Policy allows coverage to continue for totally disabled employees and your company makes the total disability determination, it is not necessary to submit a Group Disability claim application to Aetna.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Premium Waiver (*continued*)

Disabilities – general information

If an employee is away from work due to disease or injury and the employee is not able to meet the test of disability or was late in applying for the disability extension, Life Insurance may be continued by payment of premiums for up to a maximum of 12 months from the date the employee last worked. You have the option of discontinuing this continuation period at any time. At the end of this continuation period, the employee must apply (that is, convert) for a policy of individual insurance in order to remain covered for Life Insurance.

Please refer to your Policy for conversion availability and timing restrictions for submitting written conversion applications and premium payments.

Disability claims – employer's role and responsibilities

If the employee has been continuously away from work for nine months due to a disability, then you should submit a notice of disability claim to Aetna's Life Insurance Service Center. This notice (that is, the Group Disability claim form) must be submitted to Aetna no later than 12 months from the date that the employee last worked. When submitting the notice, please also include with it any additional information you may have that might help Aetna substantiate that the employee is permanently and totally disabled.

Upon approval of a claim for PW benefits, you should immediately discontinue payment of any Life Insurance charges for the disabled employee's coverage. For policies without a Premium Waiver extension, premium payments must continue in order for Life Insurance to remain in effect.

Disability claims – employee responsibilities

In addition to submitting the Life Insurance Continuation form (as described later in this chapter), when applying for PW or DBO/AID benefits, the insured employee must also have his/her physician complete the attending physician's statement form. See "Attending Physician Statement form" later in this chapter. Disabled employees who are approved for Premium Waiver or DBO/AID benefits will be periodically required to furnish proof of continuous disability. When such proof is required, we will work directly with the employee to secure the necessary documentation. If the required proof is not submitted within 31 days or if we determine the disability has ceased, Aetna reserves the right to automatically terminate coverage, with written notice to the disabled employee and a copy to you.

Disability claims – submitting notice of claim for disability benefits

Once both the Life Insurance Continuation and Attending Physician Statement forms have been completed and returned to you by the employee or the employee's representative, fax or mail them to the Life Insurance Service Center. If faxing, please fax the claim application to 1-800-238-6239.

Completing a Life Insurance Continuation form

The employee is responsible for completing Sections 1-3. As the employer, you are responsible for completing section 4.

Before submitting the Life Insurance Continuation form, please check to make sure all sections have been thoroughly completed. Missing or incomplete information will only delay approval of the disability claim.

Section 1 – Employee information

1. The employer's name.
2. If the employer has more than one location, the employee must list the location where he or she was working when disability caused active work to cease. If there is only one location, the employee should write N/A.
3. The employee's full name, first, middle, last. (Do not use nicknames or abbreviations.)
4. The employee's date of birth (day, month and year).
5. The employee's sex.
6. The employee's address (street, city, state, zip code).
7. A daytime phone number where the employee can be reached.
8. The occupation at the time of the disability.
9. The cause of the disability. If more space is needed, attach a separate sheet.

Section 2 – Attending physician

1. The name(s) of physicians treating the employee for the disability.
2. The physician's address (street, city, state, zip code).
3. The conditions the employee is being treated for.

Section 3 – Release

1. The insured's signature.
2. The date the insured signs the release.

Section 4 – Employer information

1. Your Group Policy's control number. (Refer to your Billing Statement.)
2. Your Group Policy's control suffix number. (Refer to your Billing Statement.)
3. You Group Policy's control claim account. (Refer to your billing statement.)
4. The employee's Social Security number.
5. How the employee was paid prior to his/her disability.
6. The amount of Life Insurance in force (basic and Supplemental) at the time the disability began.
7. The employee's rate of basic earnings when the disability began.
8. The reason the employee did not return to work after the last day worked.
9. The date the employee last worked.
10. If insurance was not in force on the date the disability began, list the date the insurance discontinued.
11. Please check the type of disability provision included in your Group Policy.
12. The date the employee first began work for you.
13. The date the employee's insurance took effect.
14. Indicate whether the employee had previously been required to furnish Evidence of Insurability. If yes, give the date the evidence was submitted.
15. Complete this section only if the employee is covered for Paid-Up Life Insurance.
16. If the employee contributes toward the cost of Life Insurance coverage, the date the employee's last contribution covered him/her for (period ending).
17. The employer's address (street, city, state, zip code).
18. A daytime number where the person completing this form can be reached.
19. Signature of an authorized company representative.
20. Date signed.

Please note: Applications for PW must include beneficiary forms. Applications for PW or DBO/AID that include a supplemental benefit must include enrollment forms.

Attending Physician's Statement form

The employee should complete the Patient Information and the Employer Information sections before giving the form to his/her physician. The remaining sections, 1-10, and the Remarks section are to be completed by the physician who is primarily responsible for the care and treatment of the employee.

When the application has been reviewed, you and the employee will be notified of the decision.

Once the Life Insurance Continuation form and Attending Physician's Statement form have been completed and returned to you by the employee or the employee's representative, fax or mail them to the Life Insurance Service. Please send the forms to us using the pink envelope (GC-1327). If mailing, please be sure you send the forms to the address listed for disability claims (see Customer Service Information chapter.) If faxing, please fax the claim application to 1-800-238-6239.

Life Insurance Continuation – Permanent & Total Disability Claim

Aetna

Life Insurance Continuation
Permanent & Total Disability Claim

Submit to: **Aetna Life Insurance Company**
P.O. Box 14548
Lexington, KY 40512-4548

- Employee completes Sections 1 - 3.
- Employer completes Section 4.
- Please submit this form along with completed Attending Physician Statement to the above address.

1. Employee Information

Employer Name		Branch
Employee Name	Birthdate *(MM/DD/YYYY)*	Sex ☐ Male ☐ Female
Address (street, city, state, zip code)		Daytime Telephone Number ( )
Occupation	Cause of Disability	

2. Attending Physician Information

List the physician(s) now attending you. Use back if more space is needed)

Physician's Name	Physician's Address	Condition Treated

3. Release

To all providers of health care:
You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Patient's or Authorized Person's Signature _____ Date _____

4. Employer Information

Control Number	Coverage Code: TRM1	Control Suffix	Claim Account	Social Security Number
				- -

Employee is ☐ Hourly ☐ Salary	Amount of Insurance in Force on Date Last Worked $	Rate of Basic Earnings on Date Last Worked $ _____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually

Reason Employee Did Not Return to Work After Last Day Worked	Date Last Worked	Effective Date Insurance Discontinued if Not in Force

Type of Coverage ☐ DBO-AID ☐ PTD *(check one)*: ☐ Premium Waiver ☐ Installment, provide terms _____ Months ☐ Lump Sum	Date Employee First Began Work	Date Insurance Took Effect

Was employee required to submit evidence of insurability? ☐ No ☐ Yes, give date submitted _____	Rate of Basic Earnings on Date Last Worked ***(complete only if employee elected Paid-up Coverage)*** $ _____ Contributions from last renewal date $ _____ Contributions for policy year prior to last renewal date
Last Contribution Covered Period Ending ***(complete only if employee contributed part of premium)***	Contributions should cease upon completion of this form if policy is Paid-up Insurance. If contributions are for Term Insurance only, check one of the following: ☐ Term ☐ Permanent

Employer's Address (street, city, state, zip code)	Telephone Number ( )

Signature of Employer's Authorized Representative	Date

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5. Misrepresentation	Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially 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. **Attention Arkansas, Louisiana and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention California, Ohio and Pennsylvania Residents:** 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 materially 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. **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** 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 materially 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 may subject such person to criminal and civil penalties. **Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties **Attention New York Residents:** 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 materially 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **Attention North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties. **Attention Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Attention Oregon Residents:** Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties. **Attention Washington Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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Aetna

Attending Physician's Statement

- You may use the Remarks section on the reverse side if you need more room to respond.
- The patient is responsible for completion of this form without expense to the company.

Please complete this form and return it to: **Aetna Life Insurance Service Center**
P.O. Box 14548
Lexington, KY 40512-4548
Fax Number: 1-800-238-6239

If you have any questions, please contact the Customer Service Unit at 1-800-523-5065.

Patient Information

Name	Social Security Number	Birthdate (MM/DD/YYYY)

Address (include No. Street, Town, State, Zip Code) ☐ Address is new

Release

To all providers of health care:
You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrator and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Aetna may provide the employer named below with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Note: If the person signing this is the guardian or attorney-in-fact for the claimant forward a copy of the appointment papers to Aetna and send a copy to the Attending Physician.

Employee or Authorized Person's Signature	Date (MM/DD/YYYY)

Employer Information

Name and Address	Control Number

1. History

(a) Height _____ Weight _____
(b) Date symptoms first appeared or accident happened..... Mo. _____ Day _____ Yr. _____
(c) Date patient ceased work because of disability ..... Mo. _____ Day _____ Yr. _____
(d) Has patient ever had same or similar condition? ☐ No ☐ Yes, state when and describe.
(e) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown
(f) Names and addresses of other treating physicians
Name _____ Address _____
Name _____ Address _____
Name _____ Address _____

2. Diagnosis

(a) Date of last examination ..... Mo. _____ Day _____ Yr. _____
(b) ICD diagnostic code (**mandatory**)
(c) Diagnosis (including any complications) _____
(d) Subjective symptoms

(e) Objective findings (including **current** X-rays, EKG's, laboratory data and any **clinical findings**):
(1.) **Clinical Findings**:

(2.) **Diagnostic Studies and Results**:

(f) If disability is due to pregnancy, the expected delivery date is ... Mo. _____ Day _____ Yr. _____
(g) Other disease or infirmity affecting present condition _____

3. Dates of Treatment

(a) Date of first visit ..... Mo. _____ Day _____ Yr. _____
(b) Date of last visit ..... Mo. _____ Day _____ Yr. _____
(c) Frequency ..... ☐ Weekly ☐ Monthly ☐ Other (specify) _____
(d) Is patient still under your care for this condition?
☐ Yes ☐ No, indicate date service terminated. _____

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Attending Physician's Statement

Patient Information	Name	Social Security Number

4. Nature of Treatment

(a) Type and dates of treatment:

(b) Prescribed medications:

(c) Surgical procedures and dates:

5. Progress

(a) Patient has ..... ☐ Recovered ☐ Improved ☐ Stabilized ☐ Retrogressed

(b) Patient is ..... ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

(c) Has patient been hospital confined?

☐ No ☐ Yes, give name and address of hospital _____

_____

Confined from _____ through _____

6. Cardiac (if applicable)

(a) Functional capacity limitation (American Heart Ass'n): ☐ Class 1 (none) ☐ Class 2 (slight) ☐ Class 3 (marked) ☐ Class 4 (complete)

(b) Blood Pressure (last visit): _____ / _____ Systolic / Diastolic

7. Limitations

(a) What are patient's present capabilities?

_____

(b) What are present limitations (physical and/or mental)?

_____

(c) What restrictions are placed on patient?

_____

8. Physical Impairment

*As defined in Federal Dictionary of Occupational Titles.

☐ Class 1 - No limitation of functional capacity; capable of heavy work*. No restrictions. (0-10%)

☐ Class 2 - Medium manual activity.* (15-30%)

☐ Class 3 - Slight limitation of functional capacity; capable of light work.* (35-55%)

☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)

☐ Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%)

☐ Remarks: _____

_____

9. Mental/ Nervous Impairment (if applicable)

Please define "stress" as it applies to this claimant.

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? ☐ No ☐ Yes

10. Prognosis

(a) What is the patient's prognosis?

☐ Guarded ☐ Good ☐ Fair ☐ Poor ☐ Other

(b) When do you feel patient's maximum medical improvement will be reached?

☐ 1 Mo. ☐ 1-3 Mos. ☐ 3-6 Mos. ☐ 6-9 Mos. ☐ 1 yr. or longer

(c) What is the estimated date of the patient's return to work?

☐ own job/occ ☐ other occ ☐ no return expected

(d) Do you consider the patient to be a viable candidate for **Vocational Rehabilitation** (job retraining)?

☐ Yes ☐ No, please explain _____

_____

Remarks

Attending Physician's Name (print)	Specialty	Degree

Address (No. Street, City, State, Zip Code)	Telephone

Signature	Date

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Attending Physician's Statement

Misrepresentation	Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially 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. **Attention Arkansas, Louisiana and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention California, Ohio and Pennsylvania Residents:** 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 materially 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. **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. 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If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Accelerated Death Benefit

What is ADB?

If your Group Policy includes the Accelerated Death Benefit ('ADB') feature, employees and spouses of the employees may be eligible to receive an early payment of their Life Insurance benefit in the event they are diagnosed with a terminal illness.

What is the definition of terminal illness under ADB?

An employee or spouse is considered terminally ill if he or she suffers from an incurable, progressive and medically recognized condition and, to a reasonable medical probability and based on generally accepted prognostic protocol, will not survive normally more than six, 12 or 24 months, dependent on the policy language.

How much is payable?

The minimum ADB that can be requested is $5,000,* the maximum ADB that may be requested is up to 75 percent of the total Life Insurance amount, not to exceed $500,000 dependant on the Policy language. Upon payment of the ADB, the person's Life Insurance amount will be reduced by the amount of the benefit received as shown in the following example. Premiums will also be reduced accordingly.

Policies vary so check your Group Policy for the specific terms that apply to this benefit.

Example:

(a) Amount of Life Insurance prior to a request for an ADB = $100,000

(b) ADB requested and approved at 50 percent = $50,000

(c) Amount of Life Insurance remaining after payment of the ADB = $50,000

The above terms apply in most instances; however, they may vary from state to state. In addition, the ADB may be reduced by an interest charge. Please refer to the Accelerated Death Benefit section of your Group Policy for the specific terms that apply to your Policy.

More information

If your Group Policy includes the ADB feature, a letter that explains the ADB feature for employees is shown next. Aetna recommends that you copy this letter on your company letterhead and give it to your employees when they first become covered for Life Insurance. Again, this letter should only be given to employees if your Policy includes the ADB feature.

In the unfortunate event of terminal illness, you or the employee must request an Accelerated Death Benefit Claim Kit. The claim kit contains all the necessary forms, including instructions a person will need to follow in order to request an ADB. A sample ADB form is shown later in this chapter.

*CT - No minimum; NY - The lesser of $50,000 and 25 percent of the amount of your Life Insurance then in force; PA -25 percent of the death benefit amount.

Plan sponsor letter to employees

Dear Employee:

Terminal illness is not a subject many of us want to talk about, much less experience. However, in planning for the future, each of us needs to consider this situation and its impact on our family's emotional and financial well-being.

We need to consider the fact that the impact of a terminal illness does not end when the person dies. The cost of services and treatment not covered under your health insurance plan can have a serious impact on your family's financial health during and following the illness.

To help you preserve your life savings, we are introducing an Accelerated Death Benefit under the Group Term Life Insurance policy issued by Aetna Life Insurance Company.

The following questions and answers will help you understand how this feature works.

What is an Accelerated Death Benefit (ADB)?
ADB, often referred to as a living benefit, provides an early payment of up to 75 percent of the Life Insurance benefit available under your or your spouses term life policy, in the event you or your spouse is diagnosed with a terminal illness.

An employee or spouse is considered terminally ill if he or she suffers from an incurable, progressive and medically recognized condition, and, to a reasonable medical probability and based on generally accepted prognostic protocol, will not survive more than 6,12 or 24 months. Aetna will make the final determination based on medical documentation submitted by your physician.

Who is eligible for ADB?
The ADB feature is available to covered employees and covered spouses. It does not apply to covered children.

How does an individual activate this benefit?
You may apply through your company's benefits department, which will provide you with a claim form. The benefit is payable in a lump sum. You should consult your tax professional to determine the consequences of this benefits payment.

Upon payment of the ADB, the policy participant's Life Insurance coverage will be reduced by the amount of the benefit received. Premiums will also be reduced accordingly.

What is the cost of ADB?
There is no additional cost included in the Life Insurance rates. The ADB payment, however, may be reduced by an interest charge. The interest charge will be calculated on the amount of the benefit you elect to receive. Typically, the interest rate used is the current yield on 90-day Treasury Bills, as of the date of application for the ADB.

If you need more information about ADB, contact the Benefits department.

Sincerely,

(Name)
(Title)
(Company)

*CT - No minimum; NY - The lesser of $50,000 and 25 percent of the amount of your Life Insurance then in force; PA -25 percent of the death benefit amount.

Accelerated Death Benefit (Standard Option)

****INSTRUCTION PAGE****

Enclosed please find:

- An Application for Accelerated Death Benefit
- A Request for Medical Documentation letter
- Two Authorizations to Release Information
- An Authorization to Obtain Information
- Attending Physician's Statement
- A sample letter to the employee
- An Accelerated Death Benefit Disclosure Statement
- An Accelerated Death Benefit Assignee Consent Form
- A Questions and Answer Sheet
- Accelerated Death Benefit Forms on File Server Guide

Steps to follow:

1. Complete the Employer section of the "Application for Accelerated Death Benefit" and forward it with the remainder of the forms to the employee.
2. For employees and spouses of an employee who are eligible for an Accelerated Death Benefit, Aetna provides the member with valuable and direct access to a licensed social worker who can assist them with the delivery of their life, health care and emotional needs. Our care advocate is sensitive to the physical, emotional, spiritual and culturally diverse needs of individuals and families who are facing tough decisions associated with a life-limiting illness. Our dedicated care advocate is available to the member during normal business hours and is available to assist the member with any questions they may have with completing the enclosed forms and may be reached by calling: **1-800-276-5120**.
3. If coverage is contributory, forward the current and prior 2 years enrollment forms through the Portal by attachment or by fax to 1-800-238-6239 or by mailing the forms to Aetna, P.O. Box 14549, Lexington, KY 40512-4549. **To overnight the information send it to: ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509**.
4. Forward the Accelerated Death Benefit claim kit to the employee.
5. The employee is to complete the Employee section of the "Application for Accelerated Death Benefit" form and return it with the signed copies of the "Authorization to Release Information" and the "Authorization to Obtain Information" forms to the Aetna. If assistance is needed during the claim process, contact our Customer Service Unit at 1-800-523-5065.
6. If the employee has completed an Absolute Assignment, the Assignee must authorize the Aetna to review the Accelerated Death Benefit claim and to issue benefits to the insured. The employee must send the "Assignee Consent" form to the Assignee. The Assignee must complete the form and return it to Aetna. The completed forms may be mailed or faxed to:
   Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
   Fax Number 1-800-238-6239. To overnight the information send it to ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.
7. The employee is to complete the "Request for Medical Documentation letter" and the remaining "Authorization to Release Information" form and send them to their physician(s) along with the Attending Physician's Statement.
8. The medical documentation should then be mailed or faxed to:
   Aetna Life Insurance Service Center, P.O. Box 14549, Lexington KY 40512-4549
   Fax Number: 1-800-238-6239 along with a copy of the "Request for Medical Documentation letter".
   To overnight the medical documentation send it to: ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.

Aetna®

Application for Accelerated Death Benefit

☐ **Employee** ☐ **Spouse**

Employee: Have you assigned your benefits to another person or entity? ☐ Yes ☐ No
If yes, please provide the following information:
Assignee Name _____
Address _____
Telephone Number _____
The completed form must be mailed or faxed to Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549 Fax Number 1-800-238-6239. To overnight the information send it to ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.

Plan Sponsor: Please complete **Section A** and forward the package to the employee. When the employee returns the information please forward it along with the claimant's prior two years enrollment forms to:
Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
Fax Number: 1-800-238-6239. To overnight the information send it to:
ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.

Section A:

Employer Name and Address	Control-Suffix-Account-Plan _____-_____-_____ _____ Control-Suffix-Account-Plan _____-_____-_____ _____ Amount of Basic Insurance $ _____ (TRM1 or 2) Amount of Optional Insurance $ _____ (TRM3 or 4)

1. If insurance is based on earnings, basic rate of earnings on date last worked.
$_____ per ☐ Hour ☐ Week ☐ Month ☐ Year

2. a. Effective Date of Employee's Insurance _____
b. Effective Date of Spouse's Insurance _____

3. Are premiums still being paid on this employee? ☐ Yes ☐ No

4. Sex ☐ Male ☐ Female

5. Date Employed

6. Date Last Worked

7. Employee Certificate Number or Social Security Number

8. Was the employee required to submit evidence of insurability? ☐ Yes ☐ No
Note: If yes, date evidence submitted:

9. What is the Disability Provision? ☐ Premium Waiver ☐ PTD ☐ DBO-AID ☐ DBO
Our Premium Waiver department will contact you regarding your eligibility.

10. Has employee submitted a claim for permanent total disability? ☐ Yes ☐ No
Note: If yes, date claim submitted:

11. Maximum allowable ADB
Basic $_____ and/or _____%
Optional $_____ and/or _____%

_____ Date _____ Signature of Employer's Benefit Representative _____ Telephone

Employee: Please complete **Section B**. Return this application together with the Insurer's Copy of the "Authorization to Release Information" form to your employer. Your medical records can be sent directly to the Aetna at the address above.

Section B: ***** *PLEASE PRINT OR TYPE THE INFORMATION BELOW* *****

Employee's Name & Address	Date of Birth	Social Security Number	Telephone Number
Spouse's Name & Address (if applicable)	Date of Birth	Social Security Number	Telephone Number
Caregiver Name & Address	Telephone Number	Relationship to Claimant	

Is the claimant currently residing at home? ☐ Yes ☐ No If no, please provide the name, address and telephone number of the current residence.

Do you have medical coverage through Aetna? ☐ Yes ☐ No
If yes, please provide your ID Number _____ Group Number _____
Member Services Telephone Number _____ (This information is found on your Aetna ID card).
If no, please provide the following:
Name and Address of your Medical insurer _____
Group/Plan Number _____ Member ID Number _____ Insurer's Telephone Number _____

Amount of accelerated death benefit requested: Basic $_____ and/or _____%
Optional $_____ and/or _____%

Note: The amount you request cannot exceed the amount shown in box 11.

For policy's issued in New York or Claimant's residing in New York: Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, policyowners or certificate holders should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents. Further, receipt of accelerated death benefits may be taxable. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, policyowners or certificate holders should seek assistance from a qualified tax advisor. In addition, no health care facility as defined in section 20 of the Public Health Law can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.
This application for accelerated death benefits is voluntary and without coercion on the part of any third party.
Within 5 days of receipt of this completed application form Aetna will provide an acknowledgement letter to the policy owner or certificate holder containing the information specified in New York Insurance Law §3230 (d). New York Insurance Law §3230 (c) prohibits Aetna from paying accelerated death benefits for a period of 14 days from the date on which the information specified in New York Insurance Law §3230 (d) is transmitted in writing to the policy owner or certificate holder. The completed application form must be signed and dated and received by Aetna within 30 days from the date shown on the acknowledgement letter and application.

Print name of policyowner or certificate holder _____ Signature _____ Date _____

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Claimant's Name	Social Security Number

Section C:

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially 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.

Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention California, Ohio and Pennsylvania Residents: 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 materially 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.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 materially 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 may subject such person to criminal and civil penalties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties

Attention New York Residents: 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 materially 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Date	Signature of Employee	Telephone

Aetna

Request for Medical Documentation

_____
Date

Group Policy No: _____ Employer: _____

Employee Name: _____ Employee's SSN: _____

Spouse Name (if applicable): _____ Spouse's SSN: _____

Dear Physician:

I have elected to claim part of my group life insurance benefits to which I may be entitled if my life expectancy is less than _____ months (specified under the Plan).

I must provide the following medical documentation to the Insurance Company for evaluation of benefit eligibility:

- An Attending Physician's Statement.
- A narrative summary describing the diagnosis, prognosis, modality of treatment, and clinical response to treatment,
- Clinical records for the terminal disease.
- An assessment of mental competency.
- Names, addresses, and phone numbers of other treating physicians, if applicable.
- Your assessment on the medical probability that my life expectancy will be (_____) months or less. Please provide the medical rationale in support of your opinion.
- If it is medically probable that my life expectancy will exceed (_____) please provide an opinion on my projected life expectancy. If you are unable to establish a projected life expectancy at this time, please contact me if this situation changes.

Attached is a signed Release authorizing you to submit the requested information to the Insurance Company, for their review. **Please forward the records, with a copy of this letter to assure proper identification, directly to the Insurance Company. Their address is:**
Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549.
Fax Number: 1-800-238-6239. To overnight the information send it to:
ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.

Thank you for your prompt assistance in this matter.

_____ _____
Signature of employee Date

_____ _____
Signature of spouse (if applicable) Date

Instructions: Sign and date this Request for Medical Documentation. Send this request and the Physician's copy of the Authorization to Release Medical Information form to your physician.

Aetna

Authorization To Release Information Including Release of HIV, AIDS and ARC INFORMATION

Employee's Name _____

Employee's SSN _____

Spouse's Name (if applicable) _____

Spouse's SSN _____

Employer _____

To all Physicians:

You are authorized to provide Aetna Life Insurance Company information concerning the health condition of the person for whom information is being requested. HIV tests results may be released pursuant to this release. This information will be used for the purpose of evaluating and administering a request for an Accelerated Death Benefit.

Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract.

This authorization is valid for the term of coverage of the contract under which a request for an Accelerated Death Benefit has been submitted.

Please send the required medical information immediately to:
Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
Fax Number: 1-800-238-6239. To overnight the information send it to:
ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.

I know that I have a right to receive a copy of this authorization upon request, and agree that a photographic copy of this authorization is as valid as the original. I understand that I am responsible for any charges made by my Physician for providing medical information.

_____ _____
Date Signature of employee, or his/her Authorized Representative*

_____ _____
Date Signature of spouse, or his/her Authorized Representative* (if applicable)

*If an Authorized Representative is signing this Release, please attach legal documentation as proof of such authorization to both the Physician's Copy and the Insurance Company Copy.

Instructions: Sign and date both copies of this Release. Send the Physician's copy with the Request for Medical Records to your physician. Return the Insurance Company Copy to the Employer with the Application for Accelerated Death Benefits.

Physician's Copy

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Aetna®

Authorization To Release Information Including Release of HIV, AIDS and ARC INFORMATION

Employee's Name _____

Employee's SSN _____

Spouse's Name (if applicable) _____

Spouse's SSN _____

Employer _____

Primary Care Physician Name: _____

Address: _____

Telephone #: _____

To all Physicians:

You are authorized to provide Aetna Life Insurance Company information concerning the health condition of the person for whom information is being requested. HIV tests results may be released pursuant to this release. This information will be used for the purpose of evaluating and administering a request for an Accelerated Death Benefit.

Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract.

This authorization is valid for the term of coverage of the contract under which a request for an Accelerated Death Benefit has been submitted.

Please send the required medical information immediately to:
Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
Fax Number: 1-800-238-6239. To overnight the information send it to:
ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.

I know that I have a right to receive a copy of this authorization upon request, and agree that a photographic copy of this authorization is as valid as the original. I understand that I am responsible for any charges made by my Physician for providing medical information.

_____ _____
Date Signature of employee, or his/her Authorized Representative*

_____ _____
Date Signature of spouse, or his/her Authorized Representative* (if applicable)

*If an Authorized Representative is signing this Release, please attach legal documentation as proof of such authorization to both the Physician's Copy and the Insurance Company Copy.

Instructions: Sign and date both copies of this Release. Send the Physician's copy with the Request for Medical Records to your physician. Return the Insurance Company Copy to the Employer with the Application for Accelerated Death Benefits.

Insurance Company Copy

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Aetna

Authorization To Obtain Information For Insurance Benefits

Aetna Life Insurance Service Center
P.O. Box 14549
Lexington, KY 40512-4549
Telephone Number: 1-800-523-5065
Fax Number: 1-800-238-6239

I _____
(print name)

Relationship to insured (please check one)
☐ Self
☐ Spouse
☐ Parent
☐ Personal Representative (attach copy of appointment by court)
☐ Power of Attorney/Healthcare Power of Attorney/Guardian (attach copy of appointment by court)
☐ Other _____ hereby authorize the release of

records on _____ SSN: _____
(print name)

from any physician, medical practitioner or health care professional, hospital, clinic or other medical facility, insurance company, claim administrator, bank or financial institution, credit reporting agency, university, college or institution of higher learning or employer to release the following information to Aetna Life Insurance Company (Aetna) and any independent claim administrators and consulting health professionals with whom Aetna has contracted:

- Any and all medical information (including that related to mental illness, substance abuse and/or AIDS/ARC/HIV including test results) concerning health care, advice, treatment or supplies furnished to the insured, including but not limited to, medical records, histories, physical or diagnostic examinations reports and treatment notes;
- Employment information and history, including job duties and earnings, information pertaining to my credit history;
- Information regarding school attendance, credits earned or school related activities
- Police records and reports, Autopsy and Toxicology Reports (if applicable)
- Information on all other individual and group life and accidental death and dismemberment and disability coverage, Workers' Compensation claims, and other claims filed, including amounts and dates of benefits awarded, medical records and other information related to such other claims.

Please send the required information immediately to:
Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
Fax Number: 1-800-238-6239. To overnight the information send it to:
ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.

I understand the information obtained by use of this authorization will be used for the purpose of evaluating and administering the Accelerated Death Benefit claim on the claimant, and, for the administration of any other benefit or service the claimant may be eligible for if the Application for the Accelerated Death Benefit is approved.

This authorization is valid for the term of the policy or contract under which a claim has been submitted. I understand that I may revoke this Authorization at any time by notifying Aetna in writing, but that such notification will not have any effect on actions that Aetna has taken prior to receiving my written revocation. I acknowledge that the information to be disclosed may be protected by law and that information disclosed under this authorization may be redisclosed and no longer protected by federal privacy regulations. I know that I have a right to receive a copy of this Authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Signature _____ Date: _____

Address _____

Telephone Number _____

If this authorization is being signed by the Claimant's legal representative, you must furnish a copy of the relevant document (power of attorney, health care power of attorney, court appointed guardianship papers, etc.) designating that individual as the representative.

Instructions to Claimant/Legal Representative: Sign and date this Authorization. Mail or fax the Authorization to Obtain Information fro Insurance Benefits, Insurance Company Copy, along with any relevant documents to your employer with the Application for Benefits. Send the Physician's copy along with any relevant documents to the claimant's physician.

Physician's Copy

Aetna

Authorization To Obtain Information For Insurance Benefits

Aetna Life Insurance Service Center
P.O. Box 14549
Lexington, KY 40512-4549
Telephone Number: 1-800-523-5065
Fax Number: 1-800-238-6239

I _____
(print name)

Relationship to insured (please check one)

- ☐ Self
- ☐ Spouse
- ☐ Parent
- ☐ Personal Representative (attach copy of appointment by court)
- ☐ Power of Attorney/Healthcare Power of Attorney/Guardian (attach copy of appointment by court)
- ☐ Other _____ hereby authorize the release of

records on _____ SSN: _____
(print name)

from any physician, medical practitioner or health care professional, hospital, clinic or other medical facility, insurance company, claim administrator, bank or financial institution, credit reporting agency, university, college or institution of higher learning or employer to release the following information to Aetna Life Insurance Company (Aetna) and any independent claim administrators and consulting health professionals with whom Aetna has contracted:

- Any and all medical information (including that related to mental illness, substance abuse and/or AIDS/ARC/HIV including test results) concerning health care, advice, treatment or supplies furnished to the insured, including but not limited to, medical records, histories, physical or diagnostic examinations reports and treatment notes;
- Employment information and history, including job duties and earnings, information pertaining to my credit history;
- Information regarding school attendance, credits earned or school related activities
- Police records and reports, Autopsy and Toxicology Reports (if applicable)
- Information on all other individual and group life and accidental death and dismemberment and disability coverage, Workers' Compensation claims, and other claims filed, including amounts and dates of benefits awarded, medical records and other information related to such other claims.

Please send the required information immediately to:
Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
Fax Number: 1-800-238-6239. To overnight the information send it to:
ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.

I understand the information obtained by use of this authorization will be used for the purpose of evaluating and administering the Accelerated Death Benefit claim for insurance benefits on the claimant, and, for the administration of any other benefit or service the claimant may be eligible for if the Application for the Accelerated Death Benefit is approved.

This authorization is valid for the term of the policy or contract under which a claim has been submitted. I understand that I may revoke this Authorization at any time by notifying Aetna in writing, but that such notification will not have any effect on actions that Aetna has taken prior to receiving my written revocation. I acknowledge that the information to be disclosed may be protected by law and that information disclosed under this authorization may be redisclosed and no longer protected by federal privacy regulations. I know that I have a right to receive a copy of this Authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Signature _____ Date: _____

Address _____

Telephone Number _____

If this authorization is being signed by the Claimant's legal representative, you must furnish a copy of the relevant document (power of attorney, health care power of attorney, court appointed guardianship papers, etc.) designating that individual as the representative.

Instructions to Claimant/Legal Representative: Sign and date this Authorization. Mail or fax the Authorization to Obtain Information fro Insurance Benefits, Insurance Company Copy, along with any relevant documents to your employer with the Application for Benefits. Send the Physician's copy along with any relevant documents to the claimant's physician.

Insurance Company Copy

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Aetna®

Attending Physician's Statement Accelerated Death Benefit Request

Send this form to:
Aetna Life Insurance Company
P.O. Box 14549
Lexington, KY 40512-4549
Telephone: 1-800-523-5065
Fax: 1-800-238-6239

☐ The patient is responsible for completion of this form without expense to the company.

☐ You may use the Remarks section on the reverse side if you need more room to respond. Complete this form in full.

Your patient has requested early release of a portion of his/her life insurance under the accelerated death benefit provision of the employer plan named below. In order to determine eligibility for this benefit and process this request, the following information is necessary.

Patient Information	Name	Relationship to Employee	Social Security Number	Birthdate (MM/DD/YYYY)
	Address (include No. Street, Town, State, Zip Code) ☐ Address is new			
Employer Information	Name of Employee	Name of Employer		Control Number

1. Diagnosis and History

Diagnosis (including any complications)

IDC diagnostic code (**mandatory**) | Date of last examination (MM/DD/YYYY)

Subjective symptoms

Objective findings (including **current** X-rays, EKG's, laboratory data and any **clinical findings**):
Clinical findings:

Diagnostic Studies and Results:

Are there any other illnesses, opportunistic infections, medical conditions, complications or significant findings affecting present condition? ☐ Yes ☐ No If "Yes," please describe:

Height	Weight	Are there any weight loss patterns? ☐ Yes ☐ No If "Yes," please describe:

Date symptoms first appeared or accident happened (MM/DD/YYYY)	What is the current stage of the insured's illness?	
Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes," state when and describe:	Date(s) of any recurrences (MM/DD/YYYY)	Date patient ceased work because of disability MM/DD/YYYY)

2. Nature of Treatment

Type and dates of treatment:

Prescribed Medications:

Surgical procedures and dates:

2. Nature of Treatment (cont.)

How has patient responded to treatment?

Has Patient been hospital confined? ☐ Yes ☐ No If "Yes," give name and address of hospital.

Confined from _____ Through _____

3. Progress and Limitations

Patient is: ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

What is the patient's Activities of Daily Living status.

Performance Status Scale:
Karonfsky _____%
Or ECOG (Zubrod)_____

What restrictions are placed on the patient?

4. Cardiac (if applicable)

Functional capacity limitation (American Heart Ass'n): ☐ Class 1 (none) ☐ Class 2 (slight) ☐ Class 3 (marked) ☐ Class 4 (complete

5. Mental Status

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof?
☐ Yes ☐ No

6. Prognosis

What is the patient's Prognosis?
☐ Guarded ☐ Good ☐ Fair
☐ Poor ☐ Other

On what date did you diagnose the patient as terminally ill? (MM/DD/YYYY)

Life Expectancy: Is the insured expected to die within the next 6, 9, 12, 18 or 24 months? ☐ Yes ☐ No
If "Yes," how many months until the expected date of death? _____ months

7. Treating Physicians

Names and addresses of other treating physicians

8. Remarks

Attending Physician's Name (print)	Specialty	Degree
Address (No., Street, City, State, Zip Code)		Telephone Number
Signature		Date

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9. Misrepresentation	Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially 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. **Attention Arkansas, Louisiana and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention California, Ohio and Pennsylvania Residents:** 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 materially 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. **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** 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 materially 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 may subject such person to criminal and civil penalties. **Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. 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If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties. **Attention Washington Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Aetna®

Sample Letter to Employee

<Date>

<Name>
<Address>
<City, State, Zip Code>

RE: Employee: <Employee's Name>
Plan Sponsor: <Plan Sponsor>
Control Number: <Control Number>

Dear <Name>:

We understand that you have requested to apply for an Accelerated Death Benefit. In order for Aetna Life Insurance Company, hereafter referred to as Aetna, to determine if you qualify for this benefit, please follow these instructions:

First, make sure you have received the items listed below:

- One Application for Accelerated Death Benefit
- One Request for Medical Records letter
- Two copies of the Authorization to Release Information forms
- One Authorization to Obtain Information
- One Attending Physician's Statement
- One Accelerated Death Benefit Assignee Consent form to be completed when an Absolute Assignment has been executed
- One Accelerated Death Benefit Disclosure Statement

After you have read this letter:

- Read the Disclosure Statement and keep it for your records.
- Complete and sign the employee section of the Application for Accelerated Death Benefit form. Sign and date both copies of the Authorization to Release Information forms and the Authorization to Obtain Information form. Send one copy of each completed form to the Aetna.
- Sign the Request for Medical Records letter and forward it along with the Authorization to Release Information form and the Attending Physician's Statement form to your physician. The Attending Physician's Statement and medical records must be returned to Aetna.
- If you completed an Absolute Assignment, send the Assignee Consent form to your Assignee for completion. The completed form must be returned to Aetna.

The information to be provided to Aetna may be mailed or faxed to:

Aetna Life Insurance Service Center
P.O. Box 14549
Lexington, KY 40512-4549
Fax: 1-800-238-6239

To overnight the information to Aetna send it to:

ACS, Inc.
Attn: Life Claims
101 Yorkshire Boulevard
Lexington, KY 40509

Please be certain that either you or your physician provide Aetna with the necessary medical records for our use in determining your eligibility for this benefit.

In order to avoid delays when responding to this letter, please include the name and Social Security Number for the Insured or deceased in any correspondence.

If you need assistance or have any questions, regarding your claim, please contact Aetna's Customer Service Unit at 1-800-523-5065.

Sincerely,

<Name and Title>
Aetna Life Insurance Company

cc: <Plan Sponsor's Name>

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Aetna

Aetna Life Insurance Company
Disclosure Statement at the Time of Application for Accelerated Death Benefit (ADB)

Any ADB paid by Aetna Life Insurance Company, in accordance with your request for payment under the terms of your Booklet-Certificate and the Group Policy, will be subject to the following.

While you may use the money you receive from this benefit for any purpose, including payment of long term care or nursing home expenses, the ADB in this life insurance policy is NOT part of long-term care or other nursing home coverage. Unlike conventional life insurance proceeds, an ADB payable under your life insurance coverage COULD BE TAXABLE IN SOME CIRCUMSTANCES. We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use ADB benefits.

Consequences of this Benefit:

Receipt of an ADB MAY ADVERSELY AFFECT ELIGIBILITY FOR MEDICAID AND SUPPLEMENTAL SECURITY INCOME ("SSI") ELIGIBILITY. The mere fact that your life insurance booklet-certificate includes an ADB may affect your eligibility for these government programs. In addition, exercising the option to receive an ADB and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

A. Effect on your amount of Coverage under your Booklet-Certificate: Your death benefit amount will be REDUCED if you receive an ADB. Here is an illustration of the effect an ADB payment has on your Booklet-Certificate.

   (1) Face Amount of Insurance: [$40,000]
   (2) Amount to be Accelerated (25% of Face Amount): [$10,000]
   (3) Amount of ADB Paid ([$10,000]
   (4) Amount of Insurance Remaining: [$30,000]

Ronald A Williams

Signature of Applicant

Aetna Life Insurance Company

PLEASE KEEP THIS DISCLOSURE STATEMENT FOR YOUR RECORDS

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Aetna®

Accelerated Death Benefit Assignee Consent Form

I/We _____ _____

State that I/We are of legal age and the assignee(s) of the group life insurance policy benefits payable on the life of

_____, _____ who is insured under
Insured's Name *Social Security Number*

Group policy number _____ issued by Aetna Life Insurance Company (Aetna) to

_____. I/We hereby consent and request Aetna to
Plan Sponsor Name

review and pay the Accelerated Death Benefit to _____.
Insured's Name

_____ _____ _____
Print Assignee Name *Signature* *Date*

_____ _____
Assignee Address *Telephone Number*

State/Providence of _____

County of _____

On this _____ day of _____, 20_____, personally

Appeared before me at _____

State/Providence of _____, the above named

_____
(Insert here the names of all persons making this statement)

and made oath that the statements and answers above made and subscribed are true and full.

Notary Public _____

My Commission Expires _____

Aetna

Questions and Answer Sheet

This sheet is intended to provide information on commonly asked question as by Employers and employees.

What is involved in the Claim Process?

A claim kit will be provided to you by your sales or service representative that will include:

- An Application for Accelerated Death benefit. Complete the Employer section of the application and forward it with the remainder of the forms to the employee.
- The employee is to complete the Employee section of the "Application for Accelerated Death Benefit" and return it with the "Authorization to Release Information" to their employer.
- The employer will send the "Application", "Authorization to Release Information" along with the prior two years enrollment forms to:
  Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
  Fax Number 1-800-238-6239. To Overnight the information send it to:
  ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.
- A Disclosure Statement

  (a) Standard Option. This form applies when the employee does not incur an interest charge that is deducted from his/her benefit. This document provides the claimant with basic information on how the ADB benefit will impact the life benefit.

  (b) Discount Option. This form applies when there is an interest charge deducted from the ADB payment. The interest charge deducted is equal to the current rate of a three-month United States Treasury bill in effect on the date of payment and is calculated for the period of the life expectancy period as stated in the contract.
- The employee is to complete the "Request for Medical Documentation letter" and the remaining "Authorization To Release Information" and send them to their physician(s) along with the "Attending Physician's Statement".
- The medical documentation should be sent to:
  Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
  Fax Number 1-800-238-6239. To Overnight the information send it to:
  ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509 along with a copy of the "Request for Medical Documentation letter".

ADB Forms (GC-1459 & GC 1459-1) are available on the Forms Repository:
http://aetnet.aetna.com/bts/pages/plan_sponsor/contracting_consulting/forms/all-forms.html

For State of Connecticut residents only – the interest charge is the Aetna standard rate not to exceed 8%.

What happens when Aetna receives the completed claim form and medical records?

- The entire claim file will be reviewed. Aetna may require an independent medical examination at Aetna's expense. (not applicable for State of Connecticut residents)
- When a claim is approved, the payment will be forwarded within a week either directly to the Claimant or to the Employer for distribution to the Claimant.
- When a claim is denied, we will inform the Claimant that benefits are not payable at the present time and that for a re-evaluation of his/her claim, he/she should let us know immediately when there is a change in his/her medical status.

What is the responsibility of the Claimant?

He/she must provide his/her Physician(s) with the model letter, Attending Physician's Statement and a medical release form. The Clamant is then responsible to follow up with his/her Physician and make sure the Physician provides the medical information required by Aetna in order to evaluate his/her claim.

If the claim is not approved, can the Claimant appeal the decision?

Yes, the Claimant can always appeal the claim decision. However, his/her Physician must provide up to date medical documentation that the life expectancy is within the timeframe of the policy. The Physician may also want to discuss this issue with our medical professionals.

What is the tax status of an ADB payment?

The ADB benefit received may be subject to income tax. At the end of the year Aetna reports all ADB payments to the IRS and generates a 1099 that is mailed to each Clamant. We must provide the IRS with the amount that was paid and confirm that the insured's Physician certified that the claimant is terminally ill and will die within 24 months. The employee should consult with his/her tax advisor or the IRS for additional information on the tax implications of these benefits on his/her own personal income.

What happens when the claimant dies?

The Employer should submit a proof of Death form with the death certificate and all pertinent beneficiary cards.

Where should other questions regarding this benefit be directed?

Contact your Analyst at: 1-(800) 523-5065.

Aetna

ACCELERATED DEATH BENEFIT FORMS ON FILE SERVER

Claim Kits

ADB Claim Kits (GC-1459 & GC-1459-1) are located on the Forms Repository:
http://aetnet.aetna.com/bts/pages/plan_sponsor/contracting_consulting/forms/all-forms.html

The claim kit includes the following letters and forms which are located on the Life Claim Service Center website under forms and letters.

Forms:

Instruction Page

1. Employee/Spouse Claim Application Form
2. Request for Medical Documentation
3. Authorization – Physician's Copy
4. Authorization – Insurance Company Copy
5. Disclosure Statement – Non Discount (Standard)
6. Disclosure Statement – Discount Option
7. Attending Physician's Statement
8. Accelerated Death Benefit Assignee Consent Form

Letters

1. Letter to Employee
2. Letter to Employer

Additional Documents

Located in the Life Claim website under ADB Letters:

1. EE – D – App.doc – Approval letter to employee non-discounted (standard option)
2. EE – App.doc – Approval letter to employee discount option
3. EE – Approval letter to employee – discount option for State of CT resident.doc

Accelerated Death Benefit (Discount Option)

****INSTRUCTION PAGE****

Enclosed please find:

- An Application for Accelerated Death Benefit
- A Request for Medical Documentation letter
- Two Authorizations to Release Information
- An Authorization to Obtain Information
- Attending Physician's Statement
- A sample letter to the employee
- An Accelerated Death Benefit Disclosure Statement
- An Accelerated Death Benefit Assignee Consent Form
- A Questions and Answer Sheet
- Accelerated Death Benefit Forms on File Server Guide

Steps to follow:

1. Complete the Employer section of the "Application for Accelerated Death Benefit" and forward it with the remainder of the forms to the employee.
2. For employees and spouses of an employee who are eligible for an Accelerated Death Benefit, Aetna provides the member with valuable and direct access to a licensed social worker who can assist them with the delivery of their life, health care and emotional needs. Our care advocate is sensitive to the physical, emotional, spiritual and culturally diverse needs of individuals and families who are facing tough decisions associated with a life-limiting illness. Our dedicated care advocate is available to the member during normal business hours and is available to assist the member with any questions they may have with completing the enclosed forms and may be reached by calling: **1-800-276-5120**.
3. If coverage is contributory, forward the current and prior 2 years enrollment forms through the Portal by attachment or by fax to 1-800-238-6239 or by mailing the forms to Aetna, P.O. Box 14549, Lexington, KY 40512-4549. **To overnight the information send it to: ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509**.
4. Forward the Accelerated Death Benefit claim kit to the employee.
5. The employee is to complete the Employee section of the "Application for Accelerated Death Benefit" form and return it with the signed copies of the "Authorization to Release Information" and the "Authorization to Obtain Information" forms to the Aetna. If assistance is needed during the claim process, contact our Customer Service Unit at 1-800-523-5065.
6. If the employee has completed an Absolute Assignment, the Assignee must authorize the Aetna to review the Accelerated Death Benefit claim and to issue benefits to the insured. The employee must send the "Assignee Consent" form to the Assignee. The Assignee must complete the form and return it to Aetna. The completed forms may be mailed or faxed to:
   Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
   Fax Number 1-800-238-6239. To overnight the information send it to ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.
7. The employee is to complete the "Request for Medical Documentation letter" and the remaining "Authorization to Release Information" form and send them to their physician(s) along with the Attending Physician's Statement.
8. The medical documentation should then be mailed or faxed to:
   Aetna Life Insurance Service Center, P.O. Box 14549, Lexington KY 40512-4549
   Fax Number: 1-800-238-6239 along with a copy of the "Request for Medical Documentation letter".
   To overnight the medical documentation send it to: ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.

Aetna

Application for Accelerated Death Benefit

☐ Employee ☐ Spouse

Employee: Have you assigned your benefits to another person or entity? ☐ Yes ☐ No
If yes, please provide the following information:
Assignee Name _____
Address _____
Telephone Number _____
The completed form must be mailed or faxed to Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549 Fax Number 1-800-238-6239. To overnight the information send it to ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.

Plan Sponsor: Please complete **Section A** and forward the package to the employee. When the employee returns the information please forward it along with the claimant's prior years enrollment forms to:
Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
Fax Number: 1-800-238-6239. To overnight the information send it to:
ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.

Section A:

Employer Name and Address	Control-Suffix-Account-Plan _____-____-____-_____ Control-Suffix-Account-Plan _____-____-____-_____ Amount of Basic Insurance $ _____ (TRM1 or 2) Amount of Optional Insurance $ _____ (TRM3 or 4)

1. If insurance is based on earnings, basic rate of earnings on date last worked.
$_____ per ☐ Hour ☐ Week ☐ Month ☐ Year

2. a. Effective Date of Employee's Insurance _____
b. Effective Date of Spouse's Insurance _____

3. Are premiums still being paid on this employee? ☐ Yes ☐ No

4. Sex ☐ Male ☐ Female

5. Date Employed

6. Date Last Worked

7. Employee Certificate Number or Social Security Number

8. Was the employee required to submit evidence of insurability? ☐ Yes ☐ No
Note: If yes, date evidence submitted:

9. What is the Disability Provision? ☐ Premium Waiver ☐ PTD ☐ DBO-AID ☐ DBO
Our Premium Waiver department will contact you regarding your eligibility.

10. Has employee submitted a claim for permanent total disability? ☐ Yes ☐ No
Note: If yes, date claim submitted:

11. Maximum allowable ADB
Basic $ _____ and/or _____%
Optional $ _____ and/or _____%

_____ _____ _____
Date Signature of Employer's Benefit Representative Telephone

Employee: Please complete **Section B**. Return this application together with the Insurer's Copy of the "Authorization to Release Information" form to your employer. Your medical records can be sent directly to the Aetna at the address above.

Section B: ***** PLEASE PRINT OR TYPE THE INFORMATION BELOW *****

Employee's Name & Address	Date of Birth	Social Security Number	Telephone Number
Spouse's Name & Address (if applicable)	Date of Birth	Social Security Number	Telephone Number

Caregiver Name & Address	Telephone Number	Relationship to Claimant

Is the claimant currently residing at home? ☐ Yes ☐ No If no, please provide the name, address and telephone number of the current residence.

Amount of accelerated death benefit requested: Basic $ _____ and/or _____%
Optional $ _____ and/or _____%

Note: The amount you request cannot exceed the amount shown in box 11.

For policy's issued in New York or Claimant's residing in New York: Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, policyowners or certificate holders should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents. Further, receipt of accelerated death benefits may be taxable. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for such benefits, policyowners or certificate holders should seek assistance from a qualified tax advisor. In addition, no health care facility as defined in section 20 of the Public Health Law can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

This application for accelerated death benefits is voluntary and without coercion on the part of any third party.

Within 5 days of receipt of this completed application form Aetna will provide an acknowledgement letter to the policy owner or certificate holder containing the information specified in New York Insurance Law §3230 (d). New York Insurance Law §3230 (c) prohibits Aetna from paying accelerated death benefits for a period of 14 days from the date on which the information specified in New York Insurance Law §3230 (d) is transmitted in writing to the policy owner or certificate holder. The completed application form must be signed and dated and received by Aetna within 30 days from the date shown on the acknowledgement letter and application.

Print name of policyowner or certificate holder _____ Signature _____ Date _____

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Claimant's Name	Social Security Number

Section C:

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially 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.

Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention California, Ohio and Pennsylvania Residents: 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 materially 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.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 materially 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 may subject such person to criminal and civil penalties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties

Attention New York Residents: 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 materially 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Date	Signature of Employee	Telephone

Aetna

Request for Medical Documentation

_____
Date

Group Policy No: _____ Employer: _____

Employee Name: _____ Employee's SSN: _____

Spouse Name (if applicable): _____ Spouse's SSN: _____

Dear Physician:

I have elected to claim part of my group life insurance benefits to which I may be entitled if my life expectancy is less than _____ months (specified under the Plan).

I must provide the following medical documentation to the Insurance Company for evaluation of benefit eligibility:

- An Attending Physician's Statement.
- A narrative summary describing the diagnosis, prognosis, modality of treatment, and clinical response to treatment,
- Clinical records for the terminal disease.
- An assessment of mental competency.
- Names, addresses, and phone numbers of other treating physicians, if applicable.
- Your assessment on the medical probability that my life expectancy will be (_____) months or less. Please provide the medical rationale in support of your opinion.
- If it is medically probable that my life expectancy will exceed (_____) please provide an opinion on my projected life expectancy. If you are unable to establish a projected life expectancy at this time, please contact me if this situation changes.

Attached is a signed Release authorizing you to submit the requested information to the Insurance Company, for their review. **Please forward the records, with a copy of this letter to assure proper identification, directly to the Insurance Company. Their address is:**
Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549.
Fax Number: 1-800-238-6239. To overnight the information send it to:
ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.

Thank you for your prompt assistance in this matter.

_____ _____
Signature of employee Date

_____ _____
Signature of spouse (if applicable) Date

Instructions: Sign and date this Request for Medical Documentation. Send this request and the Physician's copy of the Authorization to Release Medical Information form to your physician.

Aetna

Authorization To Release Information Including Release of HIV, AIDS and ARC INFORMATION

Employee's Name _____

Employee's SSN _____

Spouse's Name (if applicable) _____

Spouse's SSN _____

Employer _____

To all Physicians:

You are authorized to provide Aetna Life Insurance Company information concerning the health condition of the person for whom information is being requested. HIV tests results may be released pursuant to this release. This information will be used for the purpose of evaluating and administering a request for an Accelerated Death Benefit.

Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract.

This authorization is valid for the term of coverage of the contract under which a request for an Accelerated Death Benefit has been submitted.

Please send the required medical information immediately to:
Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
Fax Number: 1-800-238-6239. To overnight the information send it to:
ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.

I know that I have a right to receive a copy of this authorization upon request, and agree that a photographic copy of this authorization is as valid as the original. I understand that I am responsible for any charges made by my Physician for providing medical information.

_____ _____
Date Signature of employee, or his/her Authorized Representative*

_____ _____
Date Signature of spouse, or his/her Authorized Representative* (if applicable)

*If an Authorized Representative is signing this Release, please attach legal documentation as proof of such authorization to both the Physician's Copy and the Insurance Company Copy.

Instructions: Sign and date both copies of this Release. Send the Physician's copy with the Request for Medical Records to your physician. Return the Insurance Company Copy to the Employer with the Application for Accelerated Death Benefits.

Physician's Copy

Aetna

Authorization To Release Information Including Release of HIV, AIDS and ARC INFORMATION

Employee's Name _____

Employee's SSN _____

Spouse's Name (if applicable) _____

Spouse's SSN _____

Employer _____

Primary Care Physician Name: _____

Address: _____

Telephone #: _____

To all Physicians:

You are authorized to provide Aetna Life Insurance Company information concerning the health condition of the person for whom information is being requested. HIV tests results may be released pursuant to this release. This information will be used for the purpose of evaluating and administering a request for an Accelerated Death Benefit.

Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract.

This authorization is valid for the term of coverage of the contract under which a request for an Accelerated Death Benefit has been submitted.

Please send the required medical information immediately to:
Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
Fax Number: 1-800-238-6239. To overnight the information send it to:
ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.

I know that I have a right to receive a copy of this authorization upon request, and agree that a photographic copy of this authorization is as valid as the original. I understand that I am responsible for any charges made by my Physician for providing medical information.

_____ _____
Date Signature of employee, or his/her Authorized Representative*

_____ _____
Date Signature of spouse, or his/her Authorized Representative* (if applicable)

*If an Authorized Representative is signing this Release, please attach legal documentation as proof of such authorization to both the Physician's Copy and the Insurance Company Copy.

Instructions: Sign and date both copies of this Release. Send the Physician's copy with the Request for Medical Records to your physician. Return the Insurance Company Copy to the Employer with the Application for Accelerated Death Benefits.

Insurance Company Copy

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Aetna

Authorization To Obtain Information For Insurance Benefits

Aetna Life Insurance Service Center
P.O. Box 14549
Lexington, KY 40512-4549
Telephone Number: 1-800-523-5065
Fax Number: 1-800-238-6239

I _____
(print name)

Relationship to insured (please check one)
- ☐ Self
- ☐ Spouse
- ☐ Parent
- ☐ Personal Representative (attach copy of appointment by court)
- ☐ Power of Attorney/Healthcare Power of Attorney/Guardian (attach copy of appointment by court)
- ☐ Other _____ hereby authorize the release of

records on _____ SSN: _____
(print name)

from any physician, medical practitioner or health care professional, hospital, clinic or other medical facility, insurance company, claim administrator, bank or financial institution, credit reporting agency, university, college or institution of higher learning or employer to release the following information to Aetna Life Insurance Company (Aetna) and any independent claim administrators and consulting health professionals with whom Aetna has contracted:

- Any and all medical information (including that related to mental illness, substance abuse and/or AIDS/ARC/HIV including test results) concerning health care, advice, treatment or supplies furnished to the insured, including but not limited to, medical records, histories, physical or diagnostic examinations reports and treatment notes;
- Employment information and history, including job duties and earnings, information pertaining to my credit history;
- Information regarding school attendance, credits earned or school related activities
- Police records and reports, Autopsy and Toxicology Reports (if applicable)
- Information on all other individual and group life and accidental death and dismemberment and disability coverage, Workers' Compensation claims, and other claims filed, including amounts and dates of benefits awarded, medical records and other information related to such other claims.

Please send the required information immediately to:
Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
Fax Number: 1-800-238-6239. To overnight the information send it to:
ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.

I understand the information obtained by use of this authorization will be used for the purpose of evaluating and administering the Accelerated Death Benefit claim on the claimant, and, for the administration of any other benefit or service the claimant may be eligible for if the Application for the Accelerated Death Benefit is approved.

This authorization is valid for the term of the policy or contract under which a claim has been submitted. I understand that I may revoke this Authorization at any time by notifying Aetna in writing, but that such notification will not have any effect on actions that Aetna has taken prior to receiving my written revocation. I acknowledge that the information to be disclosed may be protected by law and that information disclosed under this authorization may be redisclosed and no longer protected by federal privacy regulations. I know that I have a right to receive a copy of this Authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Signature _____ Date: _____

Address _____

Telephone Number _____

If this authorization is being signed by the Claimant's legal representative, you must furnish a copy of the relevant document (power of attorney, health care power of attorney, court appointed guardianship papers, etc.) designating that individual as the representative.

Instructions to Claimant/Legal Representative: Sign and date this Authorization. Mail or fax the Authorization to Obtain Information fro Insurance Benefits, Insurance Company Copy, along with any relevant documents to your employer with the Application for Benefits. Send the Physician's copy along with any relevant documents to the claimant's physician.

Physician's Copy

Aetna

Authorization To Obtain Information For Insurance Benefits

Aetna Life Insurance Service Center
P.O. Box 14549
Lexington, KY 40512-4549
Telephone Number: 1-800-523-5065
Fax Number: 1-800-238-6239

I _____
(print name)

Relationship to insured (please check one)
☐ Self
☐ Spouse
☐ Parent
☐ Personal Representative (attach copy of appointment by court)
☐ Power of Attorney/Healthcare Power of Attorney/Guardian (attach copy of appointment by court)
☐ Other _____ hereby authorize the release of

records on _____ SSN: _____
(print name)

from any physician, medical practitioner or health care professional, hospital, clinic or other medical facility, insurance company, claim administrator, bank or financial institution, credit reporting agency, university, college or institution of higher learning or employer to release the following information to Aetna Life Insurance Company (Aetna) and any independent claim administrators and consulting health professionals with whom Aetna has contracted:

- Any and all medical information (including that related to mental illness, substance abuse and/or AIDS/ARC/HIV including test results) concerning health care, advice, treatment or supplies furnished to the insured, including but not limited to, medical records, histories, physical or diagnostic examinations reports and treatment notes;
- Employment information and history, including job duties and earnings, information pertaining to my credit history;
- Information regarding school attendance, credits earned or school related activities
- Police records and reports, Autopsy and Toxicology Reports (if applicable)
- Information on all other individual and group life and accidental death and dismemberment and disability coverage, Workers' Compensation claims, and other claims filed, including amounts and dates of benefits awarded, medical records and other information related to such other claims.

Please send the required information immediately to:
Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
Fax Number: 1-800-238-6239. To overnight the information send it to:
ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.

I understand the information obtained by use of this authorization will be used for the purpose of evaluating and administering the Accelerated Death Benefit claim on the claimant, and, for the administration of any other benefit or service the claimant may be eligible for if the Application for the Accelerated Death Benefit is approved.

This authorization is valid for the term of the policy or contract under which a claim has been submitted. I understand that I may revoke this Authorization at any time by notifying Aetna in writing, but that such notification will not have any effect on actions that Aetna has taken prior to receiving my written revocation. I acknowledge that the information to be disclosed may be protected by law and that information disclosed under this authorization may be redisclosed and no longer protected by federal privacy regulations. I know that I have a right to receive a copy of this Authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Signature _____ Date: _____

Address _____

Telephone Number _____

If this authorization is being signed by the Claimant's legal representative, you must furnish a copy of the relevant document (power of attorney, health care power of attorney, court appointed guardianship papers, etc.) designating that individual as the representative.

Instructions to Claimant/Legal Representative: Sign and date this Authorization. Mail or fax the Authorization to Obtain Information fro Insurance Benefits, Insurance Company Copy, along with any relevant documents to your employer with the Application for Benefits. Send the Physician's copy along with any relevant documents to the claimant's physician.

Insurance Company Copy

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Aetna®

Attending Physician's Statement Accelerated Death Benefit Request

Send this form to:
Aetna Life Insurance Company
P.O. Box 14549
Lexington, KY 40512-4549
Telephone: 1-800-523-5065
Fax: 1-800-238-6239

☐ The patient is responsible for completion of this form without expense to the company.

☐ You may use the Remarks section on the reverse side if you need more room to respond. Complete this form in full.

Your patient has requested early release of a portion of his/her life insurance under the accelerated death benefit provision of the employer plan named below. In order to determine eligibility for this benefit and process this request, the following information is necessary.

Patient Information	Name	Relationship to Employee	Social Security Number	Birthdate (MM/DD/YYYY)
	Address (include No. Street, Town, State, Zip Code) ☐ Address is new			
Employer Information	Name of Employee	Name of Employer		Control Number

1. Diagnosis and History

Diagnosis (including any complications)

IDC diagnostic code (**mandatory**) | Date of last examination (MM/DD/YYYY)

Subjective symptoms

Objective findings (including **current** X-rays, EKG's, laboratory data and any **clinical findings**):
Clinical findings:

Diagnostic Studies and Results:

Are there any other illnesses, opportunistic infections, medical conditions, complications or significant findings affecting present condition? ☐ Yes ☐ No If "Yes," please describe:

Height	Weight	Are there any weight loss patterns? ☐ Yes ☐ No If "Yes," please describe:

Date symptoms first appeared or accident happened (MM/DD/YYYY)	What is the current stage of the insured's illness?	
Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes," state when and describe.	Date(s) of any recurrences (MM/DD/YYYY)	Date patient ceased work because of disability MM/DD/YYYY)

2. Nature of Treatment

Type and dates of treatment:

Prescribed Medications:

Surgical procedures and dates:

2. Nature of Treatment (cont.)

How has patient responded to treatment?

Has Patient been hospital confined? ☐ Yes ☐ No If "Yes," give name and address of hospital.

Confined from _____ Through _____

3. Progress and Limitations

Patient is: ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

What is the patient's Activities of Daily Living status.

Performance Status Scale:
Karonfsky _____%
Or ECOG (Zubrod)_____

What restrictions are placed on the patient?

4. Cardiac (if applicable)

Functional capacity limitation (American Heart Ass'n): ☐ Class 1 (none) ☐ Class 2 (slight) ☐ Class 3 (marked) ☐ Class 4 (complete

5. Mental Status

Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof?
☐ Yes ☐ No

6. Prognosis

What is the patient's Prognosis?
☐ Guarded ☐ Good ☐ Fair
☐ Poor ☐ Other

On what date did you diagnose the patient as terminally ill? (MM/DD/YYYY)

Life Expectancy: Is the insured expected to die within the next 6, 9, 12, 18 or 24 months? ☐ Yes ☐ No
If "Yes," how many months until the expected date of death? _____ months

7. Treating Physicians

Names and addresses of other treating physicians

8. Remarks

Attending Physician's Name (print)	Specialty	Degree
Address (No., Street, City, State, Zip Code)		Telephone Number
Signature		Date

9. Misrepresentation	Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially 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. **Attention Arkansas, Louisiana and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention California, Ohio and Pennsylvania Residents:** 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 materially 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. **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** 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 materially 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 may subject such person to criminal and civil penalties. **Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **Attention New York Residents:** 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 materially 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **Attention North Carolina Residents**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties. **Attention Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Attention Oregon Residents:** Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties. **Attention Washington Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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Sample Letter to Employee

<Date>

<Name>
<Address>
<City, State, Zip Code>

RE: Employee: <Employee's Name>
Plan Sponsor: <Plan Sponsor>
Control Number: <Control Number>

Dear <Name>:

We understand that you have requested to apply for an Accelerated Death Benefit. In order for Aetna Life Insurance Company, hereafter referred to as Aetna, to determine if you qualify for this benefit, please follow these instructions:

First, make sure you have received the items listed below:

- One Application for Accelerated Death Benefit
- One Request for Medical Records letter
- Two copies of the Authorization to Release Information forms
- One Authorization to Obtain Information
- One Attending Physician's Statement
- One Accelerated Death Benefit Assignee Consent form to be completed when an Absolute Assignment has been executed
- One Accelerated Death Benefit Disclosure Statement

After you have read this letter:

- Read the Disclosure Statement and keep it for your records.
- Complete and sign the employee section of the Application for Accelerated Death Benefit form.

Sign and date both copies of the Authorization to Release Information forms and the Authorization to Obtain Information form. Send one copy of each completed form to the Aetna.

- Sign the Request for Medical Records letter and forward it along with the Authorization to Release Information form and the Attending Physician's Statement form to your physician. The Attending Physician's Statement and medical records must be returned to Aetna.
- If you completed an Absolute Assignment, send the Assignee Consent form to your Assignee for completion. The completed form must be returned to Aetna.

The information to be provided to Aetna may be mailed or faxed to:

Aetna Life Insurance Service Center
P.O. Box 14549
Lexington, KY 40512-4549
Fax: 1-800-238-6239

To overnight the information to Aetna send it to:

ACS, Inc.
Attn: Life Claims
101 Yorkshire Boulevard
Lexington KY 40509

Please be certain that either you or your physician provide Aetna with the necessary medical records for our use in determining your eligibility for this benefit.

In order to avoid delays when responding to this letter, please include the name and Social Security Number for the Insured or deceased in any correspondence.

If you need assistance or have any questions, regarding your claim, please contact Aetna's Customer Service Unit at 1-800-523-5065.

Sincerely,

<Name and Title>
Aetna Life Insurance Company

cc: <Plan Sponsor's Name>

Aetna

Aetna Life Insurance Company
Disclosure Statement at the Time of Application for Accelerated Death Benefit (ADB)

Any ADB paid by Aetna Life Insurance Company, in accordance with your request for payment under the terms of your Booklet-Certificate and the Group Policy, will be subject to the following.

While you may use the money you receive from this benefit for any purpose, including payment of long term care or nursing home expenses, the ADB in this life insurance policy is NOT part of long-term care or other nursing home coverage. Unlike conventional life insurance proceeds, an ADB payable under your life insurance coverage COULD BE TAXABLE IN SOME CIRCUMSTANCES. We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use ADB benefits.

Consequences of this Benefit:

Receipt of an ADB MAY ADVERSELY AFFECT ELIGIBILITY FOR MEDICAID AND SUPPLEMENTAL SECURITY INCOME ("SSI") ELIGIBILITY. The mere fact that your life insurance booklet-certificate includes an ADB may affect your eligibility for these government programs. In addition, exercising the option to receive an ADB and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

A. Effect on your amount of Coverage under your Booklet-Certificate: Your death benefit amount will be REDUCED if you receive an ADB. Here is an illustration of the effect an ADB payment has on your Booklet-Certificate.

   (1) Face Amount of Insurance: [$40,000]
   (2) Amount to be accelerated (25% of Face Amount): [$10,000]
   (3) Amount of ADB paid ([$10,000, less $176 interest charge: [$9824.00]
   (4) Amount of Life Insurance Remaining: [$30,000]

Ronald A Williams

_____
Signature of Applicant

Aetna Life Insurance Company

PLEASE KEEP THIS DISCLOSURE STATEMENT FOR YOUR RECORDS

GC-1582-1 (3-07) MA

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Accelerated Death Benefit Assignee Consent Form

I/We _____ _____

State that I/We are of legal age and the assignee(s) of the group life insurance policy benefits payable on the life of

_____, _____ who is insured under
Insured's Name *Social Security Number*

Group policy number _____ issued by Aetna Life Insurance Company (Aetna) to

_____. I/We hereby consent and request Aetna to
Plan Sponsor Name

review and pay the Accelerated Death Benefit to _____.
Insured's Name

_____ _____ _____
Print Assignee Name *Signature* *Date*

_____ _____
Assignee Address *Telephone Number*

State/Providence of _____

County of _____

On this _____ day of _____, 20_____, personally

Appeared before me at _____

State/Providence of _____, the above named

_____
(Insert here the names of all persons making this statement)

and made oath that the statements and answers above made and subscribed are true and full.

Notary Public _____

My Commission Expires _____

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Questions and Answer Sheet

This sheet is intended to provide information on commonly asked question as by Employers and employees.

What is involved in the Claim Process?

A claim kit will be provided to you by your sales or service representative that will include:

- An Application for Accelerated Death benefit. Complete the Employer section of the application and forward it with the remainder of the forms to the employee.
- The employee is to complete the Employee section of the "Application for Accelerated Death Benefit" and return it with the "Authorization to Release Information" to their employer.
- The employer will send the "Application", "Authorization to Release Information" along with the prior two years enrollment forms to:
  Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
  Fax Number 1-800-238-6239. To Overnight the information send it to:
  ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.
- A Disclosure Statement

  (a) Standard Option. This form applies when the employee does not incur an interest charge that is deducted from his/her benefit. This document provides the claimant with basic information on how the ADB benefit will impact the life benefit.

  (b) Discount Option. This form applies when there is an interest charge deducted from the ADB payment. The interest charge deducted is equal to the current rate of a three-month United States Treasury bill in effect on the date of payment and is calculated for the period of the life expectancy period as stated in the contract.
- The employee is to complete the "Request for Medical Documentation letter" and the remaining "Authorization To Release Information" and send them to their physician(s) along with the "Attending Physician's Statement".
- The medical documentation should be sent to:
  Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
  Fax Number 1-800-238-6239. To Overnight the information send it to:
  ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509 along with a copy of the "Request for Medical Documentation letter".

ADB Forms (GC-1459 & GC 1459-1) are available on the Forms Repository:
http://aetnet.aetna.com/bts/pages/plan_sponsor/contracting_consulting/forms/all-forms.html

For State of Connecticut residents only – the interest charge is the Aetna standard rate not to exceed 8%.

What happens when Aetna receives the completed claim form and medical records?

- The entire claim file will be reviewed. Aetna may require an independent medical examination at Aetna's expense. (not applicable for State of Connecticut residents)
- When a claim is approved, the payment will be forwarded within a week either directly to the Claimant or to the Employer for distribution to the Claimant.
- When a claim is denied, we will inform the Claimant that benefits are not payable at the present time and that for a re-evaluation of his/her claim, he/she should let us know immediately when there is a change in his/her medical status.

What is the responsibility of the Claimant?

He/she must provide his/her Physician(s) with the model letter, Attending Physician's Statement and a medical release form. The Clamant is then responsible to follow up with his/her Physician and make sure the Physician provides the medical information required by Aetna in order to evaluate his/her claim.

If the claim is not approved, can the Claimant appeal the decision?

Yes, the Claimant can always appeal the claim decision. However, his/her Physician must provide up to date medical documentation that the life expectancy is within the timeframe of the policy. The Physician may also want to discuss this issue with our medical professionals.

What is the tax status of an ADB payment?

The ADB benefit received may be subject to income tax. At the end of the year Aetna reports all ADB payments to the IRS and generates a 1099 that is mailed to each Clamant. We must provide the IRS with the amount that was paid and confirm that the insured's Physician certified that the claimant is terminally ill and will die within 24 months. The employee should consult with his/her tax advisor or the IRS for additional information on the tax implications of these benefits on his/her own personal income.

What happens when the claimant dies?

The Employer should submit a proof of Death form with the death certificate and all pertinent beneficiary cards.

Where should other questions regarding this benefit be directed?

Contact your Analyst at: 1-(800) 523-5065.

Aetna

ACCELERATED DEATH BENEFIT FORMS ON FILE SERVER

Claim Kits

ADB Claim Kits (GC-1459 & GC-1459-1) are located on the Forms Repository:
http://aetnet.aetna.com/bts/pages/plan_sponsor/contracting_consulting/forms/all-forms.html

The claim kit includes the following letters and forms which are located on the Life Claim Service Center website under forms and letters.

Forms:

Instruction Page

1. Employee/Spouse Claim Application Form
2. Request for Medical Documentation
3. Authorization – Physician's Copy
4. Authorization – Insurance Company Copy
5. Disclosure Statement – Non Discount (Standard)
6. Disclosure Statement – Discount Option
7. Attending Physician's Statement
8. Accelerated Death Benefit Assignee Consent Form

Letters

1. Letter to Employee
2. Letter to Employer

Additional Documents

Located in the Life Claim website under ADB Letters:

1. EE – D – App.doc – Approval letter to employee non-discounted (standard option)
2. EE – App.doc – Approval letter to employee discount option
3. EE – Approval letter to employee – discount option for State of CT resident.doc

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Accidental Death & Personal Loss

This chapter covers the Accidental Death and Personal Loss (AD&PL) coverage.

AD&PL death benefits

A benefit may be payable if an employee suffers a bodily injury caused by an accident, and if, as a direct result of the injury loses his/her life. To be eligible for this benefit, loss of life must occur within 365 days of the accident. The 365-day time limit applies in most instances, but may vary from state to state.

When a totally disabled employee dies, the Proof of Death form must be submitted to Aetna within the filing limit indicated in your policy. If the Proof of Death form is not provided within this timeframe, benefits may be denied.

In addition to the above, your Group Policy may also provide a Seatbelt and Airbag benefit, an Education benefit, a Child Care benefit, a Coma benefit and a benefit for Repatriation of Remains. Details are provided in your Group Policy.

AD&PL death claims

Employees who are covered for Accidental Death & Personal Loss at the time of their death will generally be covered for Life Insurance as well. If the employee is covered for Life Insurance at the time of death, it will not be necessary to complete a separate Proof of Death form. To indicate that an employee may be eligible to receive an Accidental Death benefit when filing their Life Insurance claim, please check the box for AD&PL coverage shown in Section C. The beneficiary or the beneficiary's representative should supply the information required by Section F on the form.

Aetna may also request information in addition to that requested in Section F. If we request any additional information, the beneficiary or the beneficiary's representative will be expected to cooperate by furnishing us with the requested information.

If the employee is not covered for Life Insurance at the time of death, but is covered for Accidental Death and Personal Loss Coverage, it will be necessary to complete a Proof of Death form.

AD&PL and other losses

A benefit may be payable if an employee suffers a bodily injury caused by an accident, and if, as a direct result of the injury, loses:

- His or her life.
- A hand, by actual severance at or above the wrist joint.
- A foot, by actual severance at or above the ankle joint.
- An eye, involving irrecoverable and complete loss of sight in the eye.

Your Group Policy may also pay a benefit if an employee, as a direct result of an injury caused by an accident, loses:

- His/her speech or hearing. The loss must be total and deemed permanent. (A total loss of speech or hearing will be deemed permanent if the loss has been present for 12 consecutive months, unless an attending physician states otherwise.)
- The thumb and index finger of the same hand, by actual severance of entire digit. (Loss of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.)

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Accidental Death & Personal Loss (*continued*)

Your Group Policy may also pay a benefit if an employee loses his/her life due to exposure to natural or chemical elements, disappears as a direct result of an accident, or suffers a bodily injury in an accident; and if, within 30 days after the accident and as a direct result of the injury, he/she suffers a coma or is stricken with one of the following forms of paralysis:

- Quadriplegia – the entire and irrecoverable paralysis of both upper and lower limbs.
- Paraplegia – the entire and irrecoverable paralysis of both lower limbs.
- Hemiplegia – the entire and irrecoverable paralysis of the upper and lower limbs on one side of the body.
- Uniplegia – the entire and irrecoverable paralysis of one limb.

Please refer to the Accidental Death and Personal Loss Coverage section of your Group Policy for the coverage amounts and specific terms that apply to your Group Policy.

AD&PL limitations

Benefits are payable for losses caused by accidents only. There may be situations when a benefit is not payable as the loss was not caused by an accident. Benefits may not be payable if the loss was caused or contributed to by:

- Bodily or mental infirmity.
- Disease, ptomaine or bacterial infection*.
- Suicide or attempted suicide (sane or insane).
- Medical or surgical treatment*.
- Intentionally self-inflicted injury.
- War or any act of war (declared or undeclared).
- Voluntary inhalation of poisonous gases.
- Commission of or attempt to commit a criminal act.
- Use of alcohol, intoxicants or drugs, except as prescribed by a physician. An accident in which the blood alcohol level of the operator of a motor vehicle meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred shall be deemed to be caused by the use of alcohol.
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release.
- Air or space travel. This does not apply if a person is a passenger, with no duties at all, on an aircraft being used to carry passengers (with or without cargo).

This is not an exhaustive list of the limitations but an example of the usual standard limitations. Please check your Group Policy for the entire list of limitations.

AD&PL claims

If an employee or a dependent that is covered for Accidental Death and Dismemberment suffers a covered loss, the Accidental Dismemberment Claim form that follows must be completed.

Note: Aetna recommends that you fax the Accidental Dismemberment Claim form to Aetna at 1-800-238-6239. It is not necessary to mail the originals. If you elect to mail the Accidental Dismemberment Claim form to Aetna, please send the originals to the address indicated on the Accidental Dismemberment Claim form. A sample form is shown later in this chapter.

How do I complete an Accidental Dismemberment Claim form?

- The employee is responsible for completing Section 1 and signing Section 2. You are responsible for completing Section 3.
- The covered person's physician is responsible for completing and signing the Physician Statement section on the reverse side of the form.
- When the covered person or the covered person's representative returns the completed form to you, check to make sure that Sections 1 and 2 and the Physician's Statement have been thoroughly completed. If any of the required information is missing, it will only delay benefits payments.
- If all the required information has been provided, complete and sign Section 3 before submitting the claim to the Aetna Life Insurance Service Center.

*This does not apply if the loss is caused by an infection that results directly from the injury or if surgery needed because of the injury.

Section 1: The employee completes all boxes of this section. It includes:

1. Employee's name (last, first, middle initial).
2. Employee's date of birth.
3. Employee's Social Security number.
4. Employee's current address, including street, city, state and zip code.
5. A daytime number where the employee can be reached.
6. Employee's present occupation.
7. The date the accident occurred.
8. Details of the accident: submit police/accident report with any available newspaper clippings concerning the accident. If the loss was suffered by a covered dependent, provide the dependent's full name (last, first, middle initial), date of birth and Social Security number.
9. List the name(s), address(es) and phone numbers of any physician(s) who treated the employee or dependent for the injury.
10. The employee should indicate whether he or she is eligible for workers' compensation and why.
11. The employee should indicate whether he or she is covered for any other accident insurance. Give company(ies) name(s) and policy numbers if known.

Section 2: The employee signs and dates this section granting Aetna the right to perform its contractual obligations.

Section 3: The employer completes all boxes of this section. It includes:

12. Employer's name.
13. Employer's current address, including street, city, state and zip code.
14. A daytime number where a representative of the employer can be reached.
15. Control number (see your billing statement).
16. Control suffix (see your billing statement).
17. Claim account (see your billing statement).
18. Plan code, if any (see your billing statement).
19. Date the employee or dependent became covered for AD&PL.
20. Amount of AD&PL coverage in force on the date of the accident.
21. If coverage for an employee or dependent has ceased, the effective date of discontinuance.
22. If the employee contributes toward the cost of AD&PL coverage, the date the employee's last contribution covered them for (period ending).
23. Was the employee actually working at the time of the accident?
24. If the employee was not actively at work at the time of the accident, what was the date last worked.
25. The amount and method of paying the employee at the time of the accident.
26. Was the accident work related? If yes, explain.
27. Signature of an authorized company representative.
28. Date signed.

Physician's Statement

The physician who was primarily responsible for treating the covered person's injury completes all sections, signs and dates the form.

Investigating a claim

All AD&PL claims require investigation to establish that benefits are payable in accordance with your Group Policy. During the investigation, the beneficiary will be kept informed. The investigation will usually include, but is not limited to, securing police, autopsy, toxicology reports and medical records. We may also use an outside vendor to assist us.

If it is determined that the beneficiary is not entitled to the benefit, he or she will be notified in writing, explaining the reason for the adverse claim determination and the process for requesting a review should they disagree.

The beneficiary will be provided an opportunity to appeal our decision and will be asked to document the reason he or she believes the claim should be paid.

Aetna®

Accidental Dismemberment/Personal Loss Claim Form

Submit to:
Aetna Life Insurance Company
Life Insurance Service Ctr.
P.O. Box 14549
Lexington, KY 40512-4549
Telephone: 1-800-523-5065
Fax: 1-800-238-6239

- Employer completes Section 1
- Employee completes Section 2.
- Injured Person completes sections 3 and 4.
- Physician completes the Physician Statement on the reverse side.
- Ultra Benefit Claim Statement Sections completed as needed.
- Submit to Aetna: Claim form, Enrollment form, Attending Physician's Statement, the applicable Enhanced Personal Protection form(s) Ultra Benefits Statement.

Please print all information

1. Employer Information

Name						Fax Number
						( )
Address (street, city, state, zip code)						Daytime Telephone Number
						( )
Control Number	Suffix	Account	Plan Code	Policy Effective Date (MM/DD/YYYY)	Employee's Effective Date (MM/DD/YYYY)	Date Insurance discontinued if not in force (MM/DD/YYYY)

Were premiums paid up to date of accident? ☐ No ☐ Yes

Rate of Basic Earnings on Date of Accident: $ _____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually

Date employee first began work (MM/DD/YYYY)	Date employee last worked, if not working (MM/DD/YYYY)	Total amount of coverage	Amount of coverage for this injury
		Basic AD&PL (ADD1 or 2) $ _____ Optional AD&PL (ADD3 or 4) $ _____	Basic AD&PL (ADD1 or 2) $ _____ Optional AD&PL Optional AD&PL (ADD3 or 4) $ _____

Was the accident a result of employment? ☐ No ☐ Yes If "Yes", explain fully:

What is the employee's current occupation?	Describe the day to day activities of the occupation or attach a copy of the job description.

Authorized Representative Signature	Authorized Representative's Printed Name	Date (MM/DD/YYYY)

2. Employee Information

Name	Sex	Birthdate (MM/DD/YYYY)	Social Security Number
	☐ Male ☐ Female		- -
Address (street, city, state, zip code)		Work Telephone Number	Home Telephone Number
		( )	( )

3. Injured Person's Information

Name		Relationship to Employee	Social Security Number
			- -
Address (street, city, state, zip code)		Birthdate (MM/DD/YYYY)	Daytime Telephone Number
			( )
Effective date of claimant's insurance	Date of Accident (MM/DD/YYYY)	Describe accident and give details of injuries sustained. (Please provide any police reports, medical records, toxicology reports and newspaper clippings related to the accident.)	

Were you hospitalized? ☐ Yes ☐ No If Yes, provide the name address of the hospital and the dates of confinement.

Please provide the hospital Admission and Discharge Summaries along with the results of any blood work performed.

Has a claim for benefits previously been submitted for this accident? ☐ Yes ☐ No If Yes, provide the insured name and benefit claimed.

List name(s), address(es), telephone number(s) of all attending physician(s).

Doctor's Name	Address	Telephone Number
		( )
		( )

Use back if More space is needed.

4. Release to be Signed by Injured Person

To all providers of health care:
You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Patient's or Authorized Person's Signature _____ **Date** _____

Note: If the person signing this form is the guardian or attorney-in-fact for the claimant forward a copy of the appointment papers to Aetna and send a copy to the Attending Physician.

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5. Misrepresentation	Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially 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. **Attention Arkansas, Louisiana and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention California, Ohio and Pennsylvania Residents:** 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 materially 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. **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** 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 materially 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 may subject such person to criminal and civil penalties. **Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **Attention New York Residents:** 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 materially 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **Attention North Carolina Residents**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties. **Attention Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Attention Oregon Residents:** Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Physician's Statement

Patient's Full Name	Date of Accident (MM/DD/YYYY)	Place of Accident	Date first consulted for injuries resulting from this accident

Diagnosis and complete description of injuries sustained:

_____

_____

_____

Did accident result in loss of: (MM/DD/YYYY)

(A) Right hand? Date ____/____/____ Location of amputation (at, above or below wrist) _____

(B) Left hand? Date ____/____/____ Location of amputation (at, above or below wrist) _____

(C) Right foot? Date ____/____/____ Location of amputation (at, above or below ankle) _____

(D) Left foot? Date ____/____/____ Location of amputation (at, above or below ankle) _____

(E) Thumb and index finger (same hand) Date ____/____/____ Location of amputation (at, above or below metacarpophalangeals) _____

(F) Sight of right eye? Date ____/____/____ Is loss entire and irrecoverable? _____

(G) Sight of left eye? Date ____/____/____ Is loss entire and irrecoverable? _____

What was vision at last observation?

With Glasses O.D. _____ O.S. _____ Date (MM/DD/YYYY) ____/____/____

Without Glasses O.D. _____ O.S. _____ Date (MM/DD/YYYY) ____/____/____

Date corrected vision was irrecoverably reduced to 20/200 or less and the level of the vision, in the injured eye, as of that date.

O.D. _____ O.S. _____ Date (MM/DD/YYYY) ____/____/____

Vision can be restored in whole or in part by: O.D. ☐ Lenses ☐ Treatment ☐ Operations ☐ Not restorable
O.S. ☐ Lenses ☐ Treatment ☐ Operations ☐ Not restorable

(MM/DD/YYYY)

(H) Speech? Date ____/____/____ Is loss total and permanent? _____

(I) Hearing? Date ____/____/____ Is loss total and permanent? _____

(J) Quadriplegia? Date ____/____/____ Is loss entire and irrecoverable? _____

(K) Paraplegia? Date ____/____/____ Is loss entire and irrecoverable? _____

(L) Hemiplegia? Date ____/____/____ Is loss entire and irrecoverable? _____

(M) Uniplegia? Date ____/____/____ Is loss entire and irrecoverable? _____

(N) Third Degree Burn? Date ____/____/____ How much of the body received third degree burns? _____%

(O) Coma? Start Date ____/____/____ Is the patient still in a Coma? ☐ Yes ☐ No
If No, Enter End Date ____/____/____

(P) Any other covered loss, as referenced in the AD&D section of the employer's booklet?

Was the loss sustained due solely to the above accident? ☐ Yes ☐ No

If "No", please give details of any active medical condition or disease which caused or contributed to the loss:

_____

_____

_____

Was the hospitalization of the claimant due solely to the above accident? ☐ Yes ☐ No

Were the inquiries or impairment caused by an accident or condition associated with employee's occupation? ☐ Yes ☐ No

If "Yes", explain fully:

_____

_____

Physician's Address (street, city, state, zip code)	Daytime Telephone Number ( )
Physician's Signature	Date (MM/DD/YYYY)

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If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Life Conversion

Employees who are covered for Life Insurance must be given the right to convert their coverage to a policy of individual insurance when coverage ceases because employment is terminated, when they are no longer part of a class of employees eligible for Life Insurance coverage, or because of age, pension or retirement. Dependent Life Insurance may be converted when the employee terminates employment or when the employee is no longer in a class eligible for Life Insurance coverage, and only in those situations.

The following terms apply in most instances; however, they may vary from state to state. Please refer to the conversion section of your Group Policy for the specific terms that apply to your Policy.

When should an employee apply for a life conversion policy?

During the 31 days immediately following one of the events described to the left, the person may convert his/her coverage to a Guaranteed Cost Whole Life Insurance policy, which is a cash-value policy, provided he or she submits the conversion application and remits the first premium payment for the conversion policy within the 31 days. If the person does not submit the application and the first premium payment within 31 days, the application may still be accepted; however, it will be subject to Medical Evidence of Insurability.

Some states allow more than 31 days for conversion in certain circumstances. For example, several states require employers to give written notice of termination of group coverage and conversion rights within 15 days of termination. If written notice is not provided, the application time period may be extended and the employer may be liable for claims incurred within this extended period. Please refer to the Conversion section of your Group Policy for the specific terms that apply conversion.

How does Premium Waiver affect life conversion?

If the employee terminates employment due to total disability and applies for extension under the Premium Waiver provision (see the Premium Waiver section for details on this provision), the conversion application and the first premium payment must be submitted by you within 31 days from the date coverage terminates. If the employee is subsequently approved for Premium Waiver coverage, the conversion policy will be cancelled and all premium payments will be returned.

Can employees convert to an individual policy when the policy discontinues?

In partial or complete policy discontinuance situations, employees who have been continuously insured for a period of time (generally five years) are entitled to convert a designated amount (generally $2,000 or $10,000, depending on the law of the state where the contract is issued) to an individual policy. If the employee has not been continuously insured for the time specified in the Group Policy, the employee (or former employee) will not be eligible to convert his/her coverage.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

What happens if a person dies during the 31-day life conversion application period?

If the person dies during the 31-day application period and before his/her individual policy goes into effect, the amount payable under the Group Policy will be limited to the maximum that could have been converted. This applies even if the person has not applied for the individual policy.

How does the employee apply for a policy of individual insurance?

The form that must be completed is a two-part form. The first part of the form is called the Conversion of Group Life Insurance form, which you must complete before giving the form to the employee. Even if the employee (or former employee) has no intention of converting his or her group Life Insurance coverage to a policy of individual insurance, you should still complete the Conversion of Group Life Insurance form and give it to the employee when he or she is eligible to convert. As noted above, failure to provide the form may result in the application time period being extended and the **employer** may be liable for claims incurred within this extended period.

The second part of the form is called the Application for Conversion of Group Term Life Insurance. The employee (or former employee) is responsible for completing this section and sending the entire form to the address shown on the form.

Both sections of the form provide step-by-step instructions for completing the form along with instructions for calculating the premium for the individual policy. If you or the employee (or former employee) needs assistance completing a Conversion form, call the toll-free number for the Life Insurance Service Center listed on this page.

Sample Conversion of Group Life Term Insurance and Application for Conversion of Group Term Life Insurance forms are shown on pages 97-100.

If you need to order additional Conversion forms, please refer to the Customer Service Information chapter of this handbook for ordering instructions.

Aetna

Life · Disability · Long Term Care

Conversion of Group Term Life Insurance

Aetna Life Insurance Company

Application and payment of the first premium must be made within the time limit shown in your certificate or policy.

BRIEF DESCRIPTION OF CONVERSION PRIVILEGE

Subject to the terms of the Group Policy (as described in your group insurance certificate): (1) you may apply for an individual life insurance policy in conversion of your Group Term Life Insurance and (2) the individual policy may be for the same amount which you are losing by termination of your insurance under the Group Policy, or for a lesser amount, depending upon the circumstances of the termination.

No medical examination is required, but application and payment of the first premium must be made within 31 days of the date your Group Term Insurance terminates.

Premiums may be paid annually, semi-annually, or quarterly by direct bill; or monthly by Aetna's Automatic Check Plan (ACP). Premiums may be paid other than annually only if the periodic premium is at least $15.

NOTICE OF ELIGIBILITY STATEMENT (To be completed by the Employer)

1. Name of Employer _____
2. Group Policy (Control) Number or Employee Policy Number _____
3. Suffix and Account Number (example 12-345) _____
4. Name of Employee _____
5. Employee Social Security Number _____
6. Date life insurance began _____
7. a. Date employment or eligibility terminated _____
   b. If totally disabled at this time, please state specific cause _____
   c. Last day worked if other than date in 7(a) _____
8. a. Date life insurance canceled (Do not include 31 day extended coverage period.) _____
   b. Reason for cancellation of Group Insurance _____
9. a. Amount of insurance canceled ..... Supplemental/Optional _____ Basic _____ Total _____
   b. Amount of insurance remaining in force (when insurance is reduced due to an age or retirement reduction rule) _____
10. Beneficiary (Name and Relationship) _____
11. a. Date written notice of conversion right given to employee _____
    b. If notice not furnished, show "None Given" _____
12. Complete for Dependent Conversion _____
    a. Name of dependent _____
    b. Amount of dependent Life Insurance canceled _____
13. Employee Home Telephone Number _____

Signature (Employer Authorized Representative)	Date
Address	Telephone Number

HOME OFFICE USE ONLY

Name		
Group Control Number	SCD	
Regular Group Life	Control/Suffix	Claim/Account
Pooled Group Life	Control/Suffix	Claim/Account

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WHERE TO SEND YOUR APPLICATION

You should send your application and check or money order for the initial premium to:

Aetna Life Insurance Company
Life Conversion Unit
151 Farmington Avenue
Hartford, CT 06156-1992

NOTE: Be sure the above NOTICE OF ELIGIBILITY STATEMENT has been completed by the employer.

NOTE: This folder shows premium rates for a non-participating permanent type life insurance plan. It is offered in accordance with the conversion privilege contained in the group policy. The premiums for this plan do not vary based on the sex of the applicant.

If other than the Proposed Insured is to be the policyowner, the person who will be the policyowner should sign the application as Applicant. (Where this occurs, use Section 7 "Additional Information" to designate a contingent policyowner.)

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Aetna

Application For Conversion of Group Term Life Insurance

Aetna Life Insurance Company, Hartford, Connecticut 06156

I hereby apply for a policy of insurance upon my life in accordance with the provisions of Group Policy Number _____ insuring my life as an employee of _____

1. Proposed Insured (Print Name - First, Initial, Last)	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)	Place of Birth	Telephone Number

2. Residence (Number, Street, City, County, State, Zip)

Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

3. a. Date employment terminated with above employer? Month _____ Day _____ Year _____

b. Occupation when employment terminated. Full Details.

c. What is your new occupation? Full Details.

d. Name of New Employer

4. a. Plan
Whole Life Insurance

b. Amount of Insurance (Must not exceed amount of term insurance when employment terminated.)
$

c. Premium Payable
☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ ACP/Monthly*
*Complete Deduction Form

d. Make Automatic Premium Loan Provision operative, if available.
☐ Yes ☐ No

e. Has any premium been paid and conditional receipt given on Form 265?
☐ Yes
☐ No
If "Yes," amount $_____

If "Yes," the terms of the receipt are hereby agreed to. If "No," no insurance will be effective until the entire first premium for the policy is paid within 30 days from the date of this application during the lifetime of the proposed insured, nor until the term insurance under the Group Policy ends (if under the terms of the Group Policy such insurance extends beyond the date of this application).

5. Premium Notices to be sent
☐ **Insured at Residence** ☐ **Other** _____

6. a. **Beneficiary** (NAME AND RELATIONSHIP TO PROPOSED INSURED) (NAME AND RELATIONSHIP TO PROPOSED INSURED)
Primary _____ Contingent _____
Unless otherwise requested herein, payment is to be made to primary beneficiaries who survive the Insured, equally, or if none survives, to contingent beneficiaries who survive, equally, or if none survives, to Insured's estate.

b. Policyowner (Unless otherwise requested, Proposed Insured is to be Policyowner.)

7. Additional Information (Refer to specific question number.)

IT IS MUTUALLY AGREED THAT: (1) the statements and answers made herein are complete and true to the best of my knowledge and belief; (2) issuance of the policy applied for shall be exchanged for all privileges and benefits with respect to the full amount of term insurance on my life under the Group Policy; (3) no person other than an officer of Aetna can make, modify, or discharge a contract or waive any of Aetna's rights or requirements.

Signed at _____ **on** _____
(City, State) **(Month-Day-Year)**

X_____ X_____
Witness Signature - **May Not** be a Named Beneficiary **Signature of Proposed Insured**

X_____ X_____
Print Witness Name **Signature of Applicant (if other than Proposed Insured)**

FOR HOME OFFICE USE ONLY
RECEIVED _____
INDIVIDUAL POLICY TO BE DATED _____

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DO NOT COMPLETE OR DETACH UNLESS ADVANCE PAYMENT IS MADE OF AT LEAST THE PREMIUM FOR ONE MONTH

CONDITIONAL RECEIPT

Received $_____ in connection with an Application to Aetna Life Insurance Company for Conversion of Group Term Life Insurance on the life of _____

Notice: If you do not hear from the Company concerning the proposed insurance within 60 days, notify Aetna at its Home Office at Hartford, Connecticut. READ YOUR POLICY.

IT IS MUTUALLY AGREED THAT: (1) no insurance will be effective unless this application and premium payment have been made in accordance with the terms of the Group Policy referred to in the application, if not, any payment received will be refunded; (2) the effective date of insurance applied for will be the LATER of the following dates: (a) the date of this receipt, or (b) the date the Group Term Insurance ends; and (3) if the payment is less than the first premium under the policy, the balance of that premium may be paid within 60 days from the date of this receipt. If any balance due is not paid, any insurance provided will continue only for the period which the payment will purchase on a pro rata basis.

Signed at _____ on _____
(City, State) (Month-Day-Year)

_____
(Agent)

Form 265 GR-66109 (5-02) A-POD

PREMIUM RATES FOR THE NONPARTICIPATING WHOLE LIFE PLAN

Description: Premium rates are based upon your age (nearest birthday) when the policy takes effect and do not change thereafter.

The rates included in the tables below were appropriate for the plans at the time they were prepared. The rates are subject to change without notice. You may confirm that the rates shown are the current rates by calling 1-800-523-5065.

If your policy will be at least $10,000, Tables 1 & 3 are used.

If your policy will be less than $10,000, Tables 1, 2, & 3 are used.

TABLE 1
BASIC PREMIUM RATES FOR EACH $1,000 OF INSURANCE

Age As of Your Nearest Birthday	Annual	Semi-Annual	Quarterly	ACP/ Monthly	Age As of Your Nearest Birthday	Annual	Semi-Annual	Quarterly	ACP/ Monthly
0-1	5.12	2.64	1.34	0.44	41	20.68	10.65	5.43	1.76
2	5.04	2.60	1.32	0.43	42	21.66	11.15	5.69	1.84
3	5.23	2.69	1.37	0.44	43	22.69	11.69	5.96	1.93
4	5.43	2.80	1.43	0.46	44	23.77	12.24	6.24	2.02
5	5.64	2.90	1.48	0.48	45	24.89	12.82	6.53	2.12
6	5.85	3.01	1.54	0.50	46	26.06	13.42	6.84	2.22
7	6.07	3.13	1.59	0.52	47	27.29	14.05	7.16	2.32
8	6.30	3.24	1.65	0.54	48	28.57	14.71	7.50	2.43
9	6.54	3.37	1.72	0.56	49	29.91	15.40	7.85	2.54
10	6.80	3.50	1.79	0.58	50	31.31	16.12	8.22	2.66
11	7.07	3.64	1.86	0.60	51	32.80	16.89	8.61	2.79
12	7.34	3.78	1.93	0.62	52	34.36	17.70	9.02	2.92
13	7.61	3.92	2.00	0.65	53	36.00	18.54	9.45	3.06
14	7.88	4.06	2.07	0.67	54	37.74	19.44	9.91	3.21
15	8.16	4.20	2.14	0.69	55	39.59	20.39	10.39	3.37
16	8.45	4.35	2.22	0.72	56	41.54	21.39	10.90	3.53
17	8.75	4.51	2.30	0.74	57	43.61	22.46	11.45	3.71
18	9.04	4.66	2.37	0.77	58	45.81	23.59	12.03	3.89
19	9.34	4.81	2.45	0.79	59	48.13	24.79	12.63	4.09
20	9.64	4.96	2.53	0.82	60	50.59	26.05	13.28	4.30
21	10.01	5.16	2.63	0.85	61	53.18	27.39	13.96	4.52
22	10.33	5.32	2.71	0.88	62	55.94	28.81	14.68	4.75
23	10.66	5.49	2.80	0.91	63	58.88	30.32	15.46	5.00
24	11.02	5.68	2.89	0.94	64	61.98	31.92	16.27	5.27
25	11.40	5.87	2.99	0.97	65	65.29	33.62	17.14	5.55
26	11.79	6.07	3.09	1.00	66	68.80	35.43	18.06	5.85
27	12.19	6.28	3.20	1.04	67	72.53	37.35	19.04	6.17
28	12.60	6.49	3.31	1.07	68	76.47	39.38	20.07	6.50
29	13.02	6.71	3.42	1.11	69	80.62	41.52	21.16	6.85
30	13.46	6.93	3.53	1.14	70	85.01	43.78	22.32	7.23
31	13.90	7.16	3.65	1.18	71	89.63	46.16	23.53	7.62
32	14.37	7.40	3.77	1.22	72	94.46	48.65	24.80	8.03
33	14.87	7.66	3.90	1.26	73	99.65	51.32	26.16	8.47
34	15.40	7.93	4.04	1.31	74	105.21	54.18	27.62	8.94
35	15.99	8.23	4.20	1.36	75	111.07	57.20	29.16	9.44
36	16.62	8.56	4.36	1.41					
37	17.31	8.91	4.54	1.47					
38	18.07	9.31	4.74	1.54					
39	18.88	9.72	4.96	1.60					
40	19.75	10.17	5.18	1.68					

TABLE 2
Annual Premium Surcharge

If the amount of your Policy will be less than $10,000: The annual rates shown in Table 1 are added to the surcharge shown below:

If your Policy will be:	Annual Premium Surcharge
$ 9,000 - 9,999	$ 1.00
8,000 - 8,999	2.00
7,000 - 7,999	3.00
6,000 - 6,999	4.00
Less than $6,000	5.00

TABLE 3
Policy Fee

Annual	$ 15.00
Semi-Annual	8.00
Quarterly	4.50
ACP/Monthly	2.00

NOTE: To determine your premium, see page entitled "HOW TO CALCULATE YOUR PREMIUM."

HOW TO CALCULATE YOUR PREMIUM FOR THE NONPARTICIPATING WHOLE LIFE PLAN

IF YOUR POLICY WILL BE AT LEAST $10,000

All of the following premium modes (premium frequencies) are available to you if your policy will be at least $10,000. Use Annual if you wish to pay your premiums annually, Semi-Annual if you wish to pay semi-annually, Quarterly if you wish to pay quarterly, or ACP/Monthly if you wish to pay monthly by Aetna's Automatic Check Plan.

TO CALCULATE your cost estimate use the appropriate age, policy amount, and selected premium mode.

EXAMPLE OUTLINED BELOW: AGE 40 - $20,000 Policy - **Annual** Premium payments.

	EXAMPLE	YOUR COST ESTIMATE
1. Enter the amount of insurance requested:	$20,000	
2. Amount of insurance requested in #1 divided by 1,000 equals:	20	
3. From Table 1, enter premium rate which corresponds with your age and selected premium mode:	19.75	
4. Multiply #2 x #3:	395.00	
5. From Table 3, enter appropriate policy fee based on the selected premium mode:	15.00	
6. Add #4 + #5. This equals your periodic premium payment for the premium mode you selected:	$410.00	

IF YOUR POLICY WILL BE <u>LESS THAN</u> $10,000

If you wish to pay your premiums Annually, <u>omit</u> steps #6 + #7. If you wish to pay your premiums Semi-Annually, Quarterly, or ACP/Monthly, <u>include</u> steps #6 + #7.

TO CALCULATE your cost estimate use the appropriate age and policy amount.

EXAMPLE OUTLINED BELOW: AGE 40 - $8,500 Policy - **Semi-Annual** Premium payments.

	EXAMPLE	YOUR COST ESTIMATE
1. Enter the amount of insurance requested:	$8,500	
2. Amount of insurance requested in #1 divided by 1,000 equals:	8.5	
3. From Table 1, enter **Annual** premium rate (regardless of premium mode selected) which corresponds with your age:	19.75	
4. From Table 2, enter **Annual** Premium Surcharge based on the amount of your policy:	2.00	
5. Add #3 + #4.	21.75	
*If you wish to pay your premiums Annually, **omit** steps #6 & #7.*		
6. If your premium is to be paid Semi-Annually, enter .5150 If your premium is to be paid Quarterly, enter .2625 If your premium is to be paid ACP/Monthly, enter .085	.5150	
7. Multiply #5 x #6:	11.20	
8. Multiply #2 x (#5 for Annual Payments) or (#7 for any other payment mode):	95.20	
9. From Table 3, enter appropriate policy fee based on the selected premium mode:	8.00	
10. Add #8 + #9. This equals your periodic premium payment for the premium mode selected.	$103.20	

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Portability

If your Group Policy includes the Portability feature for Life Insurance, employees can take their 100 percent contributory Life Insurance with them when they cease their employment with you or are still actively employed and no longer belong to a class of employees eligible for Life Insurance coverage, providing they are 15-98 years old. Employees who are both disabled and away from work on the date coverage ceases are not eligible. This applies in most instances; however, requirements may vary from state to state. Please refer to your Group Policy for the specific terms that apply to your Policy.

Who is eligible?

Employees are eligible for portability if they:

- Terminate employment or no longer belong to a class of eligible employees for Life Insurance coverage;
- Are covered for (Aetna) Life Insurance;
- Are 15-98 years of age; and
- Are not disabled and away from work on the date coverage would cease.

Dependents are eligible for portability if they:

- Meet the Policy's definition of a dependent on the date the employee terminates or is no longer in an eligible class, and if they are covered for Aetna Life Insurance on such date.
- Are under age 64 if a spouse; or
- Are up to the age that is one year younger than the Policy's limiting age for dependent child eligibility.

In addition, the employee must port his/her coverage in order to port a dependent's coverage.

What is the application process?

- Portability may be elected within 31 days of losing Life Insurance coverage.
- As soon as possible, provide employee with a completed Portability Option for Group Term Life Insurance form and Portability Kit (includes forms, cost and billing information). A sample form is shown later in this chapter.
- Employees who elect portability must complete the Request for Portability of Group Term Life Insurance form and return it to Aetna with the first premium contribution within the 31-day window.
- For Portability Kits, contact your Aetna service representative.
- Employees may call Aetna at the toll-free number 1-800-826-7448 with any questions.

If elected, when does portability take effect?

- At the end of the 31-day election period.

What coverage may be ported?

- 100 percent of the amount of the employee's contributory term Life Insurance for which the employee or dependent is covered on the date the employee's active coverage terminated. (On occasion, Group Policies may allow portability of noncontributory coverage. Please refer to your Group Policy to verify what coverage may be transferred.)
- Portability minimums, maximums and age reductions apply. Please see your Group Policy for details.

What if there is a death during portability?

File a standard claim form for Life Insurance. Please see the Life Claims chapter for the claim filing requirements.

What happens when portability ceases?

Employees and dependents will have a 31-day period in which to convert to an individual Life Insurance policy. Please see the conversion information described in the Life Conversion chapter for the requirements concerning conversion.

Portability Option for Group Term Life Insurance

Aetna

Portability Option for Group Term Life Insurance

Aetna Life Insurance Company - Hartford, Connecticut 06156-7350 1-800-826-7448

Read This Instruction Page Carefully

Instructions

1. Employer

Please Print

- Complete the "Portability Option for Group Term Life Insurance" section of the application.
- Be sure that:
  - All items are completed.
  - The form is signed by your authorized representative.
- Return the application to your employee instructing them to complete the "Request for Portability of Group Term Life Insurance" section of the application.

2. Employee

Please read the Fraud Notice on the back of the form, before completing.

Please Print

- Complete the "Request for Portability of Group Term Life Insurance" section of the application in its entirety.
  - Consult the Rate Tables and instructions (included in the kit) to determine insurance amounts and costs.
  - Consult the Portability Plan Outline for the:
    - Guaranteed Standard Issue amount (GSI); and
    - Portability Maximum

  If the two amounts are the same, evidence of good health will **not** be required for the coverage that you are requesting. If the Portability Maximum is more than the GSI and you are requesting more than the GSI, evidence of good health **will** be required for amounts above the GSI. If Aetna sees on your application that you are applying for more than the GSI, Aetna will send you an Evidence of Insurability form which you must complete and return to Aetna within 31-days of the date the form is sent to you.

  If after Aetna reviews the medical information you are approved for the coverage that you have requested, Aetna will send you a bill for the additional coverage, so the check that you are sending to Aetna with the application should **not** be for more than the GSI. Once you receive the bill you will have 31 days to pay for the amount that is above the GSI. If your payment is not received within 31 days, your coverage amount will be limited to the GSI.

  If Aetna is not able to approve your request for the amount that is above the GSI, your coverage will be limited to the GSI, however, you will have the option to convert the coverage that Aetna was not able to approve to an individual whole life policy, provided your application for conversion coverage is returned to Aetna within 31 days of the date on the conversion letter.
- Be sure that:
  - All items are completed.
  - The form is signed by you.
- Make a copy of the application for your records and mail the original to:

  Aetna Life Insurance Company
  Group Insurance
  151 Farmington Avenue
  Hartford, CT 06156-7350

If you have any questions, call us toll-free at:

1-800-826-7448

Please call Aetna's toll-free number if you have any questions about how to complete the Request for Portability of Group Term Life Insurance form.

GR-67113 (9-07)

Life · Disability · Long Term Care

Aetna

Portability Option for Group Term Life Insurance

Aetna Life Insurance Company - Hartford, Connecticut 06156-7350 1-800-826-7448

Request for Portability and payment of the first premium due for the frequency chosen must be made within 31 days after the date the employee's group insurance terminates.

Note: Shaded fields are required fields and MUST be completed for your Application to be processed.

Brief Description of Portability Feature

Subject to the terms of the Group Policy (as described in the Certificate of Coverage), the employee may apply for portability of their Group Term Life Insurance coverage. The Request for Portability of Group Term Life Insurance and payment of the first premium (the payment should not be for more than the Guaranteed Standard Issue amount) for the frequency chosen must be made within 31 days of the date the Group Term Life Insurance terminates, and the employee must not be both disabled and away from work on that date. If the employee is eligible to apply for more than the Guaranteed Standard Issue amount, Aetna will require evidence of the person's good health. If evidence of good health is required, Aetna will send the person, under separate cover, an Evidence of Insurability form which the person must return to Aetna within 31 days of the date it is sent to the person. If the person's evidence statement is approved, Aetna will bill separately for the additional coverage.

Premiums must be paid annually, semi-annually, or quarterly by direct bill (nominal per bill fee).

Notice of Eligibility Statement - To be Completed by the Employer (Please Print)

1. Employer Name
2. Group Policy (Control) Number
3. Division Name (If Applicable)
4. Employee Name (First, Middle Initial, Last)
5. Employee Address
6. Employee Home Telephone Number ( ) -
7. Employee Social Security Number ☐☐☐-☐☐-☐☐☐☐
8. Was employee actively at work (i.e., not disabled and away from work due to illness or injury) on date of termination? ☐ Yes ☐ No
   8a. Was termination due to retirement? ☐ Yes ☐ No
   8b. Was the employee insured for dependent life at termination? ☐ Yes ☐ No
9. Coverage Termination Date
   Month _____ Day ____ Year _____
10. Amount of Basic Life Coverage
    $ _____
    10a. Amount of Supplemental Life Coverage
    $ _____
    10b. Amount of Dependent Life Insurance
    $ _____ Spouse
    $ _____ Child
11. Annual Salary at Time of Termination
    $ _____
12. Was group plan a salary multiple schedule? ☐ Yes ☐ No
    If "Yes", provide the following information:
    a. Show salary schedule, i.e., 1X, 2X, 3X salary, etc. _____
    b. Employee Selected Salary Multiple at Time of Termination _____
    c. Was salary multiple rounded? ☐ Yes ☐ No
    If "Yes", indicate rounded amount $ _____
13. Was insurance offered in "flat" amounts ($20,000, $25,000, $35,000, etc.)? ☐ Yes ☐ No
    If "Yes":
    a. Provide "flat" amount schedule: _____
    b. "Flat" amount selected by employee $ _____
14. List Employee Most Recent Beneficiary Designation(s)

	Name (First, Middle Initial, Last)	Social Security Number	Birthdate (MM/DD/YYYY)	Relationship to Employee
a. Primary		☐☐☐-☐☐-☐☐☐☐		
b. Contingent		☐☐☐-☐☐-☐☐☐☐		

15. If term life insurance has been assigned, provide name, address and Social Security Number of assignee.
16. For dependent coverage, provide dependent names, relationship to the employee, amounts of coverage and Social Security Numbers.
17. Check other current benefit provisions employee has.
    ☐ Life Disability Benefit (Waiver of Premium) ☐ Accidental Death Amount $_____
    ☐ Accidental Death & Dismemberment Amount $ _____ ☐ Other _____

Signature (Employer Authorized Representative)

X _____

Date _____
Phone _____
Email address _____

Aetna Home Office Use Only

Date Portability Request Sent to Applicant	By CSR	Date Received	By CSR

Remarks

GR-67113 (9-07)

Aetna

Request for Portability of Group Term Life Insurance

Aetna Life Insurance Company - Hartford, Connecticut 06156-7350 1-800-826-7448

Request for Portability and payment of the first premium due for the frequency chosen must be made within 31 days after the date your group insurance terminates. The first premium payment should not be for more than the Guaranteed Standard Issue amount, if you are eligible for and are applying for more than that amount.

I hereby apply for coverage in accordance with the portability provision of the group policy issued to:
Former Employer's Name _____

Employee Coverage (Please Print – Shaded areas are required fields and **MUST** be completed

1. Employee Name (First, Middle Initial, Last)	2. Sex ☐ Male ☐ Female	3. Birthdate (MM/DD/YYYY)
4. Residence (Number, Street, City, County, State, Zip Code) 4a. Email Address _____	5. Social Security Number ☐☐☐-☐☐-☐☐☐☐ 6. Telephone Numbers (Include Area Code) Home ( ) - Work ( ) -	

7. Coverage Termination Date Month _____ Day ____ Year _____	8. Were you actively at work on your date of termination? ☐ Yes ☐ No If "No," please explain in Number 3 under "Other" (at bottom of page). Actively at work means you were not disabled and away from work due to illness or injury on the date of termination.

9. Amount of Insurance Requested (Must not exceed amount of Group Term Life Insurance when coverage terminated and is subject to the limits described in your certificate.) 9a. Guaranteed Standard Issue Amount at Termination: $ _____ 9b. Portability Maximum at Termination: $ _____	10. Other Benefits and Amounts (Check only the benefits you had at time of termination.) ☐ Accidental Death Amount $ _____ ☐ Life Disability Benefit (Waiver of Premium)

11. Have you (employee) used tobacco products (cigarettes, cigars, pipe, chewing tobacco, etc.) within the past 12 months?
☐ Yes ☐ No

Spouse Coverage (Please Print)

1. Spouse Name (First, Middle Initial, Last)	2. Sex ☐ Male ☐ Female	3. Birthdate (MM/DD/YYYY)
4. Residence (Number, Street, City, County, State, Zip Code) If different than above employee only.	5. Social Security Number ☐☐☐-☐☐-☐☐☐☐	

6. Amount of Insurance Requested (Must not exceed **spouse** amount of Group Term Life Insurance for which the employee paid the entire cost when employee coverage terminated, and must not exceed amount of employee insurance. Subject to the limits described in the employee certificate.) $ _____	7. Other Benefits and Amounts (Check only the benefits you had at time of termination.) ☐ Accidental Death Amount $ _____

8. Has spouse used tobacco products (cigarettes, cigars, pipe, chewing tobacco, etc.) within the past 12 months? ☐ Yes ☐ No

Child Coverage - Provide Information on the Youngest Child Only (Please Print)

1. Child Name (First, Middle Initial, Last)

2. Social Security Number ☐☐☐-☐☐-☐☐☐☐	3. Age	4. Birthdate (MM/DD/YYYY)	5. Sex ☐ Male ☐ Female

6. Amount of Insurance Requested (Must not exceed amount of **child** Group Term Life Insurance for which the employee paid the entire cost when employee coverage terminated, and must not exceed amount of employee insurance. Subject to the limits described in the employee certificate.)
$ _____

Beneficiary Information (Please Print)

Beneficiary(s) under Portable Group Term Life Insurance (If different than most recent designation reported to insurer by Employer. See Number 14 on the "Portability Option for Group Term Life Insurance" form.)

	Name (First, Middle Initial, Last)	Social Security Number	Birthdate (MM/DD/YYYY)	Relationship to Employee
a. Primary		☐☐☐-☐☐-☐☐☐☐		
b. Contingent		☐☐☐-☐☐-☐☐☐☐		

Beneficiary for the dependent coverage(s) applied for is the employee unless the coverage is assigned, in which case the assignee will be beneficiary.

Other (Please Print)

1. Premium Payable ☐ Annual ☐ Semi-annual ☐ Quarterly	2. Premium Amount Enclosed $ _____

3. Additional Information (Refer to specific section and question number.)

THE UNDERSIGNED UNDERSTANDS AND ACKNOWLEDGES THAT: (1) The statements and answers made herein are complete and true to the best of my knowledge and belief; (2) issuance of the portable coverage applied for shall be exchanged for all privileges and benefits under the Group Policy, including the conversion provision, with respect to the portability amount requested; (3) no person other than an officer of Aetna can make, modify, or discharge a contract or waive any of Aetna's rights or requirements; (4) no portable coverage will be effective unless this enrollment form and premium required have been made in accordance with the terms of the Group Policy; if not, any payment received will be refunded; (5) the effective date of portable coverage applied for will be 31 days following the group coverage termination date, otherwise known as the "portability date." If any balance due is not paid, any portable coverage provided will continue only for the period which the payment will purchase on a pro rata basis.

Signed at _____ on _____ X _____
City, State Date Employee Signature

GR-67114 (9-07) GR-67113 (9-07)

Portability Option for Group Term Life Insurance

Privacy Notice

In evaluating your insurability, we rely primarily on the health information you furnish to us in this statement.

Disclosure of Information

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding) and to request correction, amendment or deletion of recorded personal information in states which provide such right and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right or if you wish to have a more detailed explanation of our information practices, please contact: Aetna Life Insurance Company
Group Insurance
151 Farmington Avenue
Hartford, CT 06156-7350

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially 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.

Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention California, Ohio and Pennsylvania Residents: 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 materially 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.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 materially 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 may subject such person to criminal and civil penalties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents: 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 materially 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Continuation

In many instances, employees will be given an opportunity to continue their group coverage for a limited period of time following certain qualifying events. For example, employees not actively at work due to disease or injury or who are otherwise absent from work in order to care for a newborn or a sick family member may be allowed to continue their coverage and their dependents' coverage.

Can coverage be continued if an employee is away from work due to disease or injury?

If an employee is absent from work due to disease or injury, coverage may be continued for a limited period of time, as stated in your Group Policy. This continuation of coverage may be on a premium-paying basis, which would require continued premium payments to maintain coverage even if the employee is not actively at work. If the employee does not return to work when this "administrative" continuation period ends, the employee (and any covered dependents) may be eligible for any other continuation provision of your Group Policy (for example, FMLA) for terminated employees. After any continuation provision ends, the employee (and any covered dependents) may be eligible to convert his/her coverage to a policy of individual insurance.

Coverage for a totally disabled employee may be continued beyond any of the limits shown in your Group Policy if your Group Policy includes a total disability feature applicable to Life Insurance coverage. If this Premium Waiver disability provision were in effect on your Group Policy, you would not be required to submit premium in order for the employee's coverage to continue while they remain totally disabled. If your Group Policy does not offer a total disability feature for Life Insurance, the employee will need to convert his/her coverage to a policy of individual insurance as stated earlier. Premium payments must continue until Premium Waiver is approved.

If your Group Policy discontinues while the employee's (and any dependents') coverage is being administratively continued, coverage will cease on the date your Group Policy discontinues.

Important: As the employer, you have the discretion to decide whether you will allow coverage to continue up to the limits stated in your Group Policy or whether you will continue coverage at all. As such, we will rely upon you to notify us when you terminate the employee. Please refer to the Enrollment chapter of this handbook for instructions for terminating coverage (see item #4).

If an employee is laid off, is eligible for severance pay or on a leave of absence, can coverage be continued?

If an employee stops working because of a temporary layoff or leave of absence, coverage may be continued until the end of the month following the month in which the layoff or leave began. This is Aetna's standard policy. If Group Policies specify additional coverage, it will be honored as approved by Aetna. Premium payments must continue to be made to Aetna on behalf of the employee for coverage to continue under Severance or Leave of Absence.

If the Group Policy discontinues while the employee's coverage is being continued, coverage will cease on the date the Policy discontinues.

If you elect not to allow the employee to continue coverage or if the employee decides he or she does not want to pay for coverage to be continued, the employee's coverage should be discontinued. Please refer to the Enrollment chapter of this handbook for instructions for terminating coverage.

Examples:

- If the employee takes a short-term leave of absence on February 10, coverage can continue until March 31 of that year.
- If the employee takes a short-term leave of absence on February 10 and the Group Policy terminates on February 28, the employee's coverage will cease on February 28, the day the Policy terminates.

Can coverage be continued for handicapped dependent children?

If an employee has a child who is fully handicapped or who becomes fully handicapped before reaching the limiting age of your Group Policy for dependent children, the child's Life Insurance coverage may be continued beyond the limiting age (for example, age 19; age 23 if attending school full time) provided they have not been issued a policy of individual insurance. In order to be eligible to have coverage continued beyond your Group Policy's limiting age, the dependent child must be fully handicapped due to mental retardation or physical handicap.

A child is deemed to be fully handicapped if he or she is not able to earn his/her own living because of mental retardation or physical handicap and must depend chiefly on the employee for support and maintenance.

If the dependent child meets the definition of a fully handicapped child, proof must be submitted to Aetna no later than 31 days after the child reaches the limiting/maximum age for coverage under the Policy. The standard process is to require the completion of a medical statement by the child's attending physician. This is an Aetna form and has been tailored specifically to this need. We also reserve the right to examine the child as often as necessary to determine ongoing eligibility. An exam may not be required more than once each year after two years from the date the dependent child reached the limiting/maximum age.

Coverage for a fully handicapped dependent child will cease when the first of the following occurs:

- The date the handicap ceases.
- The date the employee or child fails to provide proof that the handicap continues when requested.
- The date the child fails to have a required exam.
- The date dependent coverage ceases under your Group Policy (except for reaching the limiting age).
- The date any required premiums cease.

The above terms apply in most instances; however, they may vary from state to state. Please refer to the General Information About Your Coverage section of your Group Policy for the specific terms that apply to your Group Policy.

If a handicapped dependent child is eligible for any Life Insurance and/or AD&PL coverage, the Aetna Life Insurance Service Center will contact the employee if proof of the handicap is required.

The Family and Medical Leave Act (FMLA)

This section is not intended for, nor should it be interpreted as, legal advice as to an employer's legal obligations under the Family and Medical Leave Act. However, if you, as an employer, determine that you will offer an employee the option to continue basic-term Life benefits during the terms of a FMLA leave of absence, then the following information describes how this will affect the Aetna Group Life Insurance coverage.

If you grant an employee a leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), the employee may be allowed to continue the Basic Term Life benefits they were covered for on the day before the FMLA leave starts. At your discretion, you may also allow the employee to continue additional benefits the FMLA does not require (for example, Supplemental Life Insurance and AD&PL coverage). This also includes coverage for the employee's eligible dependents. If the employee acquires a new dependent while their coverage is being continued under the FMLA, the new dependent may be eligible for coverage.

At the time the employee requests a leave, you must make arrangements with the employee to collect any contributions you may require for the continued coverage.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Continuation (*continued*)

If your group has any benefits that are affected by an age or retirement reduction, the employee's coverage will be subject to those rules while on a FMLA leave.

Coverage for an employee may not be continued beyond when the first of the following occurs:

- The date any required contributions cease.
- The date you determine their approved FMLA leave has ended.*
- The date coverage ceases as to the employee's eligible class.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

When an employee returns to work from an approved FMLA leave, coverage under your Group Policy may continue as though the employee had continued in active employment, provided the employee makes a request for such coverage within 31 days of the date the FMLA leave terminates. This request is with respect to those Supplemental coverages that may not have continued during the FMLA leave because you were unable to make premium payments on behalf of the employee. If the employee does not make such a request within 31 days, coverage may again be effective under your Group Policy only if Aetna gives its written consent. (An employee must request coverage in order to authorize future payroll deductions for such coverage.)

If your Group Policy provides any other continuation of coverage (for example, upon termination of employment) the employee (or eligible dependents) may be eligible for such continuation on the date their approved FMLA leave has ended. If the employee is eligible for any such continuation provision, any conversion provision will be available on the same terms as those for when employment is terminated.

State-required continuation

If your Group Policy is full-risk (or split-funded), the insurance laws of the state in which your Group Policy is issued (called the contract state) may mandate that you offer continuation to employees and/or covered dependents in certain situations. In addition, insurance law(s) of the contract state(s) may also apply to your Group Policy if the law(s) are written to apply to residents of that state, regardless of the state where the contract is issued. These are known as "extraterritorial" laws, and if they apply, employees impacted by the particular law may be eligible for continuation as prescribed.

*If you grant an approved FMLA leave for a period in excess of the FMLA-required period, any extended continuation of coverage during the excess period will be subject to approval by Aetna.

Life Claims

When an employee or dependent dies

Life benefits

Please refer to your Group Policy for the coverage amounts and specific terms that apply to your Group Policy.

Completing the life claim process

In the unfortunate event of the death or accidental death of an employee (or a retired employee) or a dependent who is covered for Life Insurance and/or Accident Death and Personal Loss Insurance, a claim for Life Insurance will have to be filed. This claim form is called the Proof of Death form. A sample form is shown later in this chapter.

In addition to the Proof of Death form, the following items are required to process a request for a Life Insurance benefit. Please use this checklist to help you assemble and attach all pertinent data before filing the claim. The items outlined below MUST accompany the Proof of Death form.

- The insured's or dependent's final death certificate with cause.* A clear photocopy is acceptable. However, if death occurs outside the United States, a certified death certificate is required.
- Current beneficiary designation and any or all prior change of beneficiary designations.
- If Life Insurance benefits have been assigned, include the registered Assignment of Group Coverage form.
- Enrollment forms for the past two enrollment periods (current and prior year) on all contributory/ voluntary benefits.
- Is the beneficiary a minor child? If so, please include a copy of the child's birth certificate and letters of guardianship* of the estate of the minor or court order* to release the proceeds for the benefit of the minor.
- If the beneficiary is the insured's estate, please attach the Letters of Testamentary or Administration.*
- If the designated beneficiary predeceased the employee, please attach a copy of the beneficiary's death certificate. Depending upon the beneficiary provision of your policy, a sole survivor affidavit executed by a family member may be necessary.
- If the death is an accidental death and Accidental Death benefits are being claimed, submit any available newspaper clippings and obituary notices concerning the accident. Additional information such as police reports, fire reports or coroner's reports may be required upon request by Aetna.*
- Complete the deceased's name and Social Security number on the top of page 2 of the Proof of Death form before submitting the claim to the Life Insurance Service Center.
- By fax – Aetna recommends that you fax the Proof of Death form and other required information to the Aetna Life Insurance Service Center at 1-800-238-6239. Please include a cover letter indicating the number of pages being faxed. If you fax information in, there is no need to mail in the originals.
- By mail – If you elect to mail the Proof of Death form and other required information to us, please mail the originals to:
  Aetna Life Insurance Service Center
  P.O. Box 14549
  Lexington, KY 40512-4549

*The beneficiary or the beneficiary's representative should supply this information to you.

Life Claims (*continued*)

Proof of Death form

Section A: Complete all boxes of this section. It includes:

1. Deceased's name (last, first, middle initial).
2. Relationship to employee (that is, self, spouse, child, etc.).
3. Deceased's Social Security number.
4. Deceased's date of birth.
5. Deceased's date of death.
6. Deceased's age at death.
7. Last residence of deceased, including street, city, state and zip code.

Section B: Complete all boxes of this section. Although all data in this section specifically refers to the employee, this information is useful for dependent claims as well:

8. Employee's name (last, first, middle initial).
9. Employee's Social Security number.
10. Employee's date of birth.
11. Date employed.
12. Hourly/salaried status.
13. Date employee last worked (indicate active if employee still working).
14. Reason employee did not return to work after last day worked (would not apply if employee is still active and claim is on a dependent).
15. Employee residence, including street, city, state and zip code.

Section C: Employer section of form:

16. Complete employer's name.
17. Complete local HR representative's name as the contact person.
18. Include street address, including city, state and zip code for contact person.
19. Complete telephone number for contact person (so we can contact you if we need additional information).
20. Check yes or no if claim was previously submitted for Accelerated Death Benefits (if applicable on your Policy).
21. Reply yes or no if waiver of premium was submitted prior to death (if applicable on your Policy).

The next section is VERY important! Please be sure to complete the appropriate information regarding the submission of each claim.

Check the appropriate box(s) on the Proof of Death form as to what insurance coverages are being submitted. If the claim is for a dependent, then the dependent should be noted. If claim is for an employee, then term life should be noted. If employee elected optional Life Insurance, then the term life and optional life boxes should both be marked.

Complete the **control, suffix, account and plan number** for each coverage (control, suffix, account and plan can vary depending on the employee status and/or location).

The **effective date of employee's insurance** must be completed. This is the original effective date of the employee becoming insured for Life Insurance.

Amount of Life Insurance in force as of date last worked. Indicate the amount of insurance being requested for each coverage being filed (make sure to calculate any plan reduction due to age).

Employee's earnings on last day worked are required when submitted coverage is calculated based on earnings.

Note: Please indicate whether the employee's pay is based on per week, per hour, per month. If insurance is based on other than earnings (that is, union negotiated benefit), then complete the box to the left of the question.

Complete HR questions regarding last payroll increase (required for salaried life); insurance percentage increase (that is, yes or no); Evidence of Insurability; last contributions (employee or employer contributions); date insurance was cancelled (if applicable); and conversion policy information provided to employee (if insurance was cancelled).

Section D: Information about the beneficiary(ies).

Note beneficiary information including name, address, Social Security number,* relationship to employee, date of birth and telephone numbers on the lines indicated.

Section E: Benefit distribution instructions.

Indicate where you would like the benefits payment directed (beneficiary, employer, beneficiary with copy to employer, other).

*Missing Social Security numbers may delay the claim payment.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Section F: General instructions on information required with the filing of life claims.

Section G: Employer's authorized representative needs to sign and date the form before submission to the Life Insurance Service Center.
If you have any questions concerning the completion of a Proof of Death form or simply want to check on the status of a claim, you may call the Life Insurance Service Center at the number listed on this page.

Investigating a claim

Claims are investigated to establish that benefits are payable in accordance with the insurance Policy. During the investigation, the beneficiary will be kept informed.

If it is determined that the beneficiary is not entitled to the benefit, he or she will be notified in writing, explaining the reason for the adverse claim determination and the process for requesting a review should they disagree.

The beneficiary will be provided an opportunity to appeal our decision and will be asked to document the reason he or she believes the claim should be paid.

Aetna®

Proof of Death

Group Life Insurance and Group Accidental Death Benefit Request
(Filing instructions on reverse side)

Please fax or mail this claim to:
Aetna Life Insurance Company
P.O. Box 14549
Lexington, KY 40512-4549
FAX: 1-800-238-6239

A. Information About the Deceased

Deceased's Name (Last, First, Middle Initial)			If deceased is known by any other name, provide Name (Last, First, Middle Initial)		
Relationship to Employee	Social Security Number	Birthdate (MM/DD/YYYY)	Date of Death (MM/DD/YYYY)	Age	Sex ☐ Male ☐ Female
Last Residence: Street			City	State	Zip

B. Information About the Employee

Employee's Name (Last, First, Middle Initial)			Social Security Number		Birthdate (MM/DD/YYYY)
Last Residence: Street			City	State	Zip
Date Employed (MM/DD/YYYY)	Work Location Name/Number		Occupation/Class		☐ Hourly ☐ Salary
Date Last Worked (MM/DD/YYYY)	Reason employee did not return to work after last day worked.				

C. Information About the Employee's Coverage

Employer's Name		Representative's / Contact's Name / Email Address		
Street Address		City	State	Zip
Telephone Number	Was an Accelerated Death Benefit, Accidental Dismemberment or Enhancement benefit such as Coma, Traumatic Brain Injury, Surgical Reattachment, Third Degree Burn, Children's Double Indemnity Benefit claim submitted prior to death? ☐ No ☐ Yes			
Fax Number	Was waiver of premium claim submitted prior to death? ☐ No ☐ Yes			

Coverages for which benefits are in effect and being claimed

Group Coverage	Control	Suffix	Account	Plan	Effective date of employee's insurance (MM/DD/YYYY)	Amount of insurance in force as of the date last worked
☐ Basic Life					/ /	
☐ _____					/ /	
☐ Supplemental Life					/ /	
☐ _____					/ /	
☐ Dependent Life					/ /	
☐ Accidental Death					/ /	
☐ Group Accident					/ /	
☐ Paid-up Life					/ /	
☐ Group Universal Life					/ /	
☐ _____					/ /	

If insurance is based on earnings, basic rate of earnings on date last worked or frozen salary
$ _____ per ☐ Hour ☐ Week, give number of hours worked per week _____ ☐ Month ☐ Year

If insurance is based on other earnings, identify type (i.e., commission, bonus, etc.) and amount. Type _____ $_____	Date of Last Salary Increase (MM/DD/YYYY)	Has amount of insurance increased (other than salary) within the last two years? ☐ No ☐ Yes If Yes, give date (MM/DD/YYYY) _____

Did the insured change his contributory coverage elections on the Aetna plan effective date?
☐ No ☐ Yes

Was employee required to submit evidence of insurability to secure current coverage? ☐ No ☐ Yes	Were premiums paid through the date of death for this insured? ☐ No ☐ Yes	If insurance is not in effect, give date discontinued (MM/DD/YYYY)

Has the deceased converted his group insurance? ☐ No ☐ Yes If Yes, give Policy Number _____	Did the deceased have an Aetna long term care policy? ☐ No ☐ Yes If Yes, give Policy Number _____

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Proof of Death

Page 2

Deceased Information

Name (Last, First, Middle Initial)
Social Security Number

D. Information About The Beneficiary(ies)

	1.	2.	3.
Name			
Street			
City			
State/Zip			
Social Security Number			
Relationship to Employee			
Birthdate (MM/DD/YYYY)			
Telephone Number:			
Home			
Work			

Has benefit/ownership been assigned?	If Yes, to whom? (send copy of assignment)	Assignee's Social Security Number
☐ No ☐ Yes		

E. Benefit Distribution Instructions

Return the benefit payment directly to:
☐ Beneficiary ☐ Employer ☐ Other _____

Employer's Claim Submission Checklist

☐ Proof of Death Claim Form
☐ Insured's certified death certificate *(stating the cause of death)*
☐ Original and all the change of beneficiary designation forms
☐ Enrollment forms or screen prints confirming *contributory* coverage elections for the current and prior two years' annual enrollment periods. If Aetna's plan effective date is 3 years or less, include current and most recent prior carrier enrollment cards.
☐ Please check if there was a family status change (marriage, birth, adoption) and include the family status change date:
_____/_____/_____
☐ Did you check the Yes or No box on the question "Were premiums paid through the date of death for this insured?"

If the beneficiary is a minor child, provide:
- ☐ A copy of the birth certificate & Social Security Number
- ☐ Letters of Guardianship or Conservatorship of the estate of the minor child or
- ☐ A completed Uniform Transfers to Minors Affidavit, if applicable

If the beneficiary is the insured's estate, provide:
- ☐ The letters of administration or letters testamentary (Court Papers naming the Administrator or Executor of the Estate)

If the beneficiary is a trust, provide:
- ☐ Copies of trust and letter of acceptance from the trustee with the Trust ID number

If the designated beneficiary has died, provide:
- ☐ A copy of the beneficiary's death certificate

If no beneficiary was named or no beneficiary survives the insured and your policy provides for payment to next in line family member(s), submit:
- ☐ A notarized Aetna Affidavit of Sole Survivors completed by a family representative or

If no beneficiary was named or no beneficiary survives the insured and your policy provides for payment to the Estate, provide:
- ☐ The letters of administration or letters testamentary (Court Papers naming the Administrator or Executor of the Estate)

If Accidental Death benefits are being claimed, provide:
- ☐ police/accident report
- ☐ autopsy report
- ☐ toxicology report (not necessary if the deceased was a passenger in a motor vehicle accident)
- ☐ any available newspaper articles concerning the accident, if available

- Complete the deceased name on the top of Page 2 before the Life insurance claim is faxed to our office at **1-800-238-6239** or **1-800-AetnaFx**. It is not necessary to follow-up with the original documents.

If you have additional questions on the submission of this claim, please contact our office at **1-800-523-5065**.

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Page 3

Deceased Information

Name (Last, First, Middle Initial)

Social Security Number

F. Employer's Authorized Representative

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially 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.

Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention California, Ohio and Pennsylvania Residents: 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 materially 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.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 materially 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 may subject such person to criminal and civil penalties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents: 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 materially 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Name _____ Signature _____

Date (MM/DD/YYYY) _____ at (city, state, zip) _____

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If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Aetna Beneficiary Solutions™

What is Aetna Beneficiary Solutions?

When a loved one dies, beneficiaries shouldn't have to face overwhelming financial and legal decisions alone. As a standard feature of Aetna Group Life policies, Aetna Beneficiary Solutions provides enhanced, confidential resources that enable beneficiaries to clearly and conveniently handle these important decisions – **at their own pace.**

Aetna Beneficiary Solutions

All Aetna Group Life policy sponsors and beneficiaries can receive the following essential services at no extra cost.

Financial counseling and investment services

All beneficiaries, no matter the payout amount, will receive free financial counseling from Chase Investment Services Corp. (CISC*), a subsidiary of JPMorgan Chase Bank. CISC is a full-service broker-dealer and registered investment advisor.

- The CISC financial consultants receive bereavement training and seek to understand the beneficiaries' short- and long-term goals, help them develop financial priorities, and then can set up an investment program to meet their objectives.
- Beneficiaries can choose from a range of investments - mutual funds, bonds, annuities, stocks/options, unit investment trusts and more.

Free Web-based legal information and discounted legal services

- A core legal services program, Legal Reference™,** will now be available to beneficiaries. Legal Reference offers access to free and discounted legal services and information that will be independently administered by Advisory Communications Systems, Inc. (ACS).

Aetna Benefits Checkbook®

- Beneficiaries receiving payouts of $5,000 or more receive an interest-bearing checking account into which the Life Insurance or AD&PL proceeds are deposited.
- The checkbook program offers beneficiaries immediate access to their funds, but allows them to take the time to make important decisions.

*Financial counseling, securities and investment advisory services are independently offered through Chase Investment Services Corp. (CISC). A member of NASD/SIPC and a subsidiary of JPMorgan Chase Bank, CISC is a full-services broker-dealer and registered investment advisor. Aetna does not warrant or guarantee and makes no representations as to the quality of services offered by CISC.

**The Legal Reference Program is independently offered and administered by Advisory Communications Systems, Inc. (ACS). Aetna Life Insurance Company does not participate in attorney selection or review and does not monitor ACS services, content or network. Aetna does not warrant or guarantees, or make any representation as to the quality of the services of ACS, or of any attorney in the ACS network.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Bill Payment

Understanding and paying your List Bill

What is a List Bill?

Under the List Bill process, statements are produced based on the benefits, the rate for each benefit and the number of employees and dependent lives (if applicable) that our administrative system indicates are enrolled in your Group Policy. The List Bill statement is also designed to maintain a list of your members for claim verification within our administrative billing system. You will receive a billing statement in advance of the statement due date.

If you have any questions regarding the information shown on your statement, please contact your Aetna representative at the number listed on your billing statement.

How do I read my List Bill?

A List Bill statement consists of eight sections. A more detailed description of each section and an example of a List Bill statement are shown on the following pages.

A. Payment Stub and Remittance section

The payment stub provides a recap of any prior balance due amounts, the current due and the total amount due. The following is a brief summary of each item found on the payment stub.

1. **Change space**
   For address and phone number changes.
2. **SCD number**
   Self-checking digit for internal use only.
3. **Control number**
   Identifies your account. It should be included on all correspondence and forms.
4. **Account name**
   The identifying name on the account.
5. **Account phone**
   Your business phone number.
6. **Servicing field office**
   The name and number representing the field office that services your account.
7. **Statement date**
   The due date for which the statement is being prepared and for which payment is expected.
8. **Grace period expires**
   The date payment of this statement must be received by Aetna to ensure continuation of your group coverage and to prevent late-charge assessment or possible cancellation.
9. **Customer name and mailing address**
   Your company's name and mailing address.
10. **Lock box remittance address**
    Address to which payment and stub should be sent.
11. **Prior balances due**
    Any unpaid balances will be reflected here.
12. **Current due**
    Indicates the amount of the current month's charge.
13. **Total amount due**
    Represents the sum of the prior balance due plus the current due. **This is the total amount that should be paid.**

    Note: The payment stub must always be detached and remitted with your payment.

B. Statement of Account section

The Statement of Account is a summary of all due and paid activity that occurs on your account and can be produced with your statement. The statement on account details the following.

1. **Statement date**
   The due date(s) of the statement(s) with prior balances that are indicated on the statement of account.
2. **Prep/paid date**
   Either the prepared date of a statement or the date a payment was applied.
3. **Transaction type**
   The type of transaction that is applicable (that is, payment).
4. **Statement due amount**
   The amount due for the statement date indicated.
5. **Paid amount**
   The amount paid for the statement date indicated.
6. **Cumulative balance**
   The balance accumulated (if any) on the account as of a particular statement date.
7. **Total amount due**
   The total amount due on the account as a result of the cumulative balance.

C. Message section

This section of your statement will contain any message that would be applicable to your account. Examples of various types of messages are indicated below:

1. The symbol "*" indicates a change to an Enrollee or dependents.
2. "CR" placed after an amount indicates a credit.
3. FOR QUESTIONS REGARDING THIS STATEMENT PLEASE CONTACT: (the individual listed on your billing statement).

D. Account/Benefit Adjustment Information section

The Account/Benefit Adjustment Information section of the statement provides details as to any adjustments made to your account for that billing period. This section will only appear on your statement when an account or benefit adjustment is applicable. This section is detailed as follows.

1. **Account/benefit**
   The type of adjustment made. An adjustment can be made to a specific benefit or to the entire account.
2. **Reason**
   The reason for the account/benefit adjustment. For example, a benefits rate revision to the entire account.
3. **Effective date of change**
   The effective date used to calculate the account/benefit adjustment.
4. **Adjustment amount**
   The amount of the adjustment applied to your account. This could be either a credit or debit adjustment.
5. **Subtotal account/benefit adjustments**
   The subtotal of all adjustments applied to the account for that billing period.

E. Enrollee Transaction Activity section

The Enrollee Transaction Activity portion of the statements displays enrollments, changes and terminations that have been processed during the current billing period. Information on this section is detailed as follows.

1. **Name, SSN, sex and birth date**
   Indicates the name, Social Security number, sex and birth date of each Enrollee.
2. **Chng-Type**
   The type of transaction (that is, New = enrollment, CHHG = change, Term = Termination).
3. **Change Eff Date**
   The effective date of the transaction.
4. **Pln**
   The plan of benefits the Enrollee is or was enrolled in.
5. **Dep**
   Indicates the number of covered dependents.
   "H" = Husband
   "W" = Wife
   The number = total number of children (for example, H1 = Husband and 1 child covered).
6. **Current Charge**
   Enrollee's current charge for that billing period.

   Note: If the effective date of the Enrollee transaction occurs on a date other than a statement due date, we will not charge or credit for the days in the initial short month. Also, retroactive enrollments are assessed charges based on current rates.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Bill Payment (*continued*)

7. **Back adjustment**
   The amount of the back adjustment if applicable. Credit or debits will be for no more than three months.
8. **Enrollee transactions**
   A subtotal of current charges and back adjustments for all transactions reflected.

F. Active/Retired Enrollees section

The Active/Retired Enrollee section of your statement, if applicable, reflects all Enrollees currently insured for that month. The following is a summary of the items displayed in this section:

1. **Name, SSN, sex and birth date**
   Indicates the name, Social Security number, and sex and birth date of each Enrollee.
2. **Effective date**
   The effective date of new coverage or last change, whichever is later, for each Enrollee insured for that billing period.
3. **Pln**
   The plan of benefits the Enrollee is or was enrolled in.
4. **Dep**
   Indicates number of covered dependents.
   "H" = Husband
   "W" = Wife
   "X" = Spouse over age 65
   The number = total number of children (for example, H1 = Husband and 1 child covered).
5. **Current charge**
   Enrollee's current charge for the billing period.
6. **Life ins amount**
   Amount of Life Insurance for each Enrollee, if applicable.
7. **Currently active**
   The number of currently active Enrollees.
8. **Current Charges**
   The subtotal of current charges for all Enrollees.

G. Benefit and Service Analysis section

The Benefit and Service Analysis section of your statement displays a summary of benefits for active Enrollees and/or dependents on your account. The following is an explanation of this portion of the statement.

1. **Benefit or service**
   Reflects each benefit or service billed on your account and for whom the benefit/service applies (for example, employee and/or dependent).
2. **Number**
   The total number of Enrollees/dependents billed for each benefit/service.
3. **Volume**
   The total volume of insurance if applicable to that benefit/service (for example, Life Insurance volume of $10,000 each for six Enrollees equals a total volume of $60,000).
4. **Rate/rate base**
   The rate and rate base for each benefit/service. For example, the life benefit may be billed on a per $1,000 basis.
5. **Current charge**
   The total current charge for all active Enrollees for each benefit/service.
6. **Adjustment**
   Total adjustment for each benefit/service.
7. **Current due**
   The total current due for each benefit. The current due is the sum of current charges plus or minus any adjustments.

H. Due Summary section

The Due Summary is the final section of your statement. It provides a recap of due amounts as follows.

1. **Total adjustments**
   The total amount of all adjustments for the current period.
2. **Current charges**
   The total current charges for all Enrollee and/or dependent activity.
3. **Statement due amount**
   The sum of total adjustments plus or minus current charges.

How do I pay my List Bill?

To ensure uninterrupted claims service, the total amount due reflected on your payment stub should be mailed to Aetna by the due date. This date is prior to the expiration date. Checks should be made payable to Aetna Inc. Your check should also include your control, suffix and account numbers. Detach the payment stub from the statement and mail with your check to the remittance address shown on the stub.

List Bill – Sample

Aetna

Ætna's Administrative System

PAYMENT STUB

PAGE 1

PLEASE INDICATE ADDRESS/PHONE CHANGE BELOW SCD: 1

CONTROL NUMBER	930081-010-00002
ACCOUNT NAME	TEST
ACCOUNT PHONE	000-000-0000
SERV FIELD OFFICE	076 MIDDLETOWN
PAYMENT DUE DATE	NOV 1, 2003

AETNA INC.
ATTN: AETNA - MIDDLETOWN
P.O. BOX 70966
CHICAGO IL 60673-0966

TEST AAS TESTING QA
ATTN: *TEST* AAS TESTING
1000 MIIDDLE ST
MIDDLETOWN CT 06457-7527

CURRENT DUE GRACE PERIOD EXPIRES DEC 2, 2003

PRIOR BALANCES DUE REFLECTING PAYMENTS THRU OCT 27, 2003	REBILLED ADJUSTMENT AMOUNT	TOTAL AMOUNT DUE
$3,919.80	$.00	$3,919.80

PLEASE DETACH STUB AT PERFORATION AND MAIL ALONG WITH YOUR PAYMENT FOR THE TOTAL AMOUNT DUE.

STATEMENT OF ACCOUNT

TEST AAS TESTING QA

CONTROL NUMBER	930081-010-00002
ACCOUNT NAME	TEST
ACCOUNT PHONE	000-000-0000
SERV FIELD OFFICE	076 MIDDLETOWN
PAYMENT DUE DATE	NOV 1, 2003

THE FOLLOWING LISTS YOUR PAYMENT DUE AMOUNTS AND PAYMENTS RECEIVED.

PAYMENT DUE DATE	PREP/PAID DATE	TRANSACTION TYPE	PAYMENT DUE AMOUNT	PAID AMOUNT	CUMULATIVE BALANCE
NOV 1 03	OCT 15 03	VOID DUE	783.30		
	OCT 20 03	VOID DUE	3,919.80		
	OCT 27 03	REBILL	3,919.80		3,919.80

TOTAL AMOUNT DUE	$3,919.80

MESSAGES

PAYMENT DUE AMOUNTS HAVE BEEN RECALCULATED DUE TO A POLICY REVISION.

IMPORTANT - PLEASE READ: THE TOTAL PREMIUM IS DUE ON THE FIRST DAY OF THE MONTHLY COVERAGE PERIOD. IF NOT RECEIVED BY THE END OF THE GRACE PERIOD, THE CONTRACT MAY BE TERMINATED. YOU WILL BE LIABLE FOR THE PREMIUM FOR ALL PERIODS OF COVERAGE (INCLUDING THE GRACE PERIOD) UNLESS YOU PROVIDE AT LEAST 30 DAYS ADVANCE WRITTEN NOTICE OF YOUR INTENT TO TERMINATE.

CR PLACED AFTER AN AMOUNT INDICATES A CREDIT.

FOR QUESTIONS REGARDING THIS STATEMENT, OR TO REPORT AN ENROLLEE TRANSACTION PLEASE CONTACT: AETNA PLAN SPONSOR SERVICES @ 888-287-4295

YOU MAY ALSO FAX EMPLOYEE TRANSACTIONS TOLL FREE TO OUR SERVICE REPRESENTATIVES AT 866-682-3862.

THIS STATEMENT REFLECTS ALL PAYMENTS AND CHANGES RECORDED AS OF THE PREPARED DATE SHOWN BELOW.

REGION: 06 SGB ADMIN ILE 00,000,042 PREPARED DATE OCT 27, 2003

List Bill – Sample

Aetna

Ætna's Administrative System

EMPLOYEE BENEFITS STATEMENT PAGE 2

TEST AAS TESTING QA

CONTROL NUMBER 930081-010-00002
ACCOUNT NAME TEST
ACCOUNT PHONE 000-000-0000
SERV FIELD OFFICE 076 MIDDLETOWN
PAYMENT DUE DATE NOV 1, 2003

ENROLLEE TRANSACTION ACTIVITY

ENROLLEE NAME	SSN OR ID	SEX	BIRTH DATE	CHNG TYPE	CHANGE EFF.DATE	PLN	DEP	CURRENT CHARGE	BACK ADJUSTMENT
J CARR	930-08-1001	M	3/30/72	NEW	11/01/03	S	W1	870.10	.00
L CARTER	930-08-1011	F	10/01/64	NEW	11/01/03	S	H	553.10	.00
K CASS	930-08-1003	F	4/15/70	NEW	11/01/03	S		261.10	.00
S CASSELL	930-08-1013	M	3/01/70	NEW	11/01/03	S	2	580.10	.00
A CATT	930-08-1002	M	12/20/66	NEW	11/01/03	S		261.10	.00
W GRANT	930-08-1009	F	6/01/55	NEW	11/01/03	S	1	580.10	.00
K KNIGHTLEY	930-08-1006	F	12/10/75	NEW	11/01/03	S		261.10	.00
D LESLIE	930-08-1007	M	9/14/50	NEW	11/01/03	S	W	553.10	.00

ENROLLEE TRANSACTIONS

8 ENROLLMENTS	.00
0 CHANGES	.00
0 TERMINATIONS	.00

SUBTOTAL OF ENROLLEE TRANSACTIONS $.00

ACTIVE/RETIRED ENROLLEES

ENROLLEE NAME	SSN OR ID	SEX	BIRTH DATE	EFFECTIVE DATE	PLN	DEP	CURRENT CHARGE	LIFE INS AMOUNT
J CARR	930-08-1001	M	3/30/72	11/01/03	S	W1	870.10	1,000
L CARTER	930-08-1011	F	10/01/64	11/01/03	S	H	553.10	1,000
K CASS	930-08-1003	F	4/15/70	11/01/03	S		261.10	1,000
S CASSELL	930-08-1013	M	3/01/70	11/01/03	S	2	580.10	1,000
A CATT	930-08-1002	M	12/20/66	11/01/03	S		261.10	1,000
W GRANT	930-08-1009	F	6/01/55	11/01/03	S	1	580.10	1,000
K KNIGHTLEY	930-08-1006	F	12/10/75	11/01/03	S		261.10	1,000
D LESLIE	930-08-1007	M	9/14/50	11/01/03	S	W	553.10	1,000

CURRENTLY ACTIVE 8 CURRENT CHARGES $3,919.80

BENEFIT AND SERVICE ANALYSIS

BENEFIT OR SERVICE		LIVES	VOLUME	RATE/RATE BASE	CURRENT CHARGE	ADJUSTMENT	CURRENT DUE
TERM LIFE	EMPL	8	8,000	.500/1000	4.00	.00	4.00
	DEP	5		2.000/EMPL	10.00	.00	10.00
ACCIDENT	EMPL	8	8,000	.600/1000	4.80	.00	4.80
MEDICAL EXPENSE	EMPL	8		260.000/EMPL	2,080.00	.00	2,080.00
	SP	2		290.000/EMPL	580.00	.00	580.00
	C	2		317.000/EMPL	634.00	.00	634.00
	SPC	1		607.000/EMPL	607.00	.00	607.00
				TOTALS	$3,919.80	$0.00	$3,919.80

NOV DUE SUMMARY

TOTAL ADJUSTMENTS	+/-	CURRENT CHARGES	=	PAYMENT DUE AMOUNT
$.00		$3,919.80		$3,919.80

REGION: 06 SGB ADMIN ILE 00,000,043 PREPARED DATE OCT 27, 2003

Bill Payment (*continued*)

Understanding and paying your Summary Bill

You will receive a billing statement based on the billing frequency of your policy, in advance of the statement due date. All statements you receive are estimated statements. You will be expected to make adjustments to each statement, calculate premium due and forward the "total premium due" directly to the remittance address on your statement along with your updated statement.

Please contact your Aetna representative upon receipt of your first bill to assist you in calculating the total premium due.

Payment must be made by the due date to ensure continued coverage for your employees.

How do I read my Summary Bill?

The following describes each section of your statement to help you understand and read your statement. A sample statement is also shown at the end of this section.

1. **Change space**
   Used to report a change of address.
2. **SCD number**
   Self-checking digit for internal use.
3. **Control number**
   Identifies your account. Consists of the control, suffix and account numbers. This information should be included in all correspondence to Aetna Inc.
4. **Statement date**
   The due date for which the statement is being prepared and on which payment is to be expected.
5. **Account name**
   The identifying name on the account.
6. **Account phone**
   Will be displayed if provided.
7. **Servicing field office**
   The name and number representing the field office responsible for your account.
8. **Customer team name**
   Applicable to National Accounts customers only.
9. **Prep date**
   Date the Summary Billing Statement was prepared.
10. **Grace period expires**
    The date payment of this statement must be received by Aetna to ensure continuation of your group coverage in order to prevent a late charge assessment as outlined in your fee scheduler.
11. **Contact name**
    The name and phone number of the individual responsible for your Group Policy. If an individual is not assigned to your Group Policy, it will show a toll-free number to call.
12. **Customer name and address**
    Identifies your name, address and the person to whose attention the summary statement is being sent. Please notify your Aetna service representative should this information change.
13. **Billing line name**
    Identifies coverage contained in the billing line.
14. **Billing line code**
    Internal code for company use to further identify the billing line.
15. **Number of employees**
    Number of employees who are covered as of the statement date. The number in the shaded area reflects the estimated number of covered employees, based on the latest finalized statement.
16. **Volume**
    Reflects the total amount of coverage for all covered employees. For example, if you have 10 employees and each has $10,000 worth of insurance, your total volume would be $100,000.
17. **Rate**
    Represents the rate that is charged for the line of coverage.
18. **Amount**
    New amount that is due for that line of coverage.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

19. **Adjustment**
    Used to correct errors in payments for previous statements. The error could be a result of incorrect reporting of lives and volume. Correction is accomplished by taking credit or charge by billing line. To avoid any delays in processing your payments, please provide an explanation of the adjustments in the space provided.
20. **Explanation of adjustment**
    When making any type of adjustment exceeding three percent of the total premium, please provide us with an explanation in this space.
21. **Total amount due**
    Recalculated amount for any change or adjustment made. If you have a multiple-page statement, total amount due goes on the last page of the statement.
22. **Estimated amount due**
    Estimated amount according to last updated figures.
23. **To properly credit your account send statement with payment**
    This is an important item: You must include a copy of the entire statement to ensure proper posting of your payment to your account and to avoid any applicable late charges.
24. **Lock box remittance address**
    The address to which the payment and completed statement must be sent.
25. **Please provide control number on your check**
    In order to ensure proper posting of your check, it is very important that you include your Group Policy's control number on your check.
26. **Signature of an authorized company representative**
    The statement must be signed by a representative of your company having the proper authority to sign such statement.

How do I complete my Summary Bill?

1. **Complete number of employees**
   Above the shaded area to the right of the asterisk, enter the total amount of employees who are covered as of the statement date.
2. **Complete volume, if applicable**
   Above the shaded area to the right of the asterisk, enter the total volume as of the statement date. The volume equals the total amount of coverage for all employees enrolled in the benefit being calculated. If the number of employees increases, the volume should also increase.
3. **Rate**
   Multiply the rate by the entry for the number of employees or volume, whichever is followed by an "X," and enter the result in the amount column.

   If your benefit line is calculated by volume, multiply the volume by the rate and divide by the rate basis.

   For example, to calculate the amount for the life benefit on the sample statement: Multiply the volume (100,000) by the rate (.090) and divide by the rate basis ($1,000) = 9.00.

   If your line is calculated based on number of employees, multiply the number of employees by the rate. Should you need assistance with this section, please contact your Aetna service representative.

   Note: Do not enter the result in the adjustment column.
4. **The adjustment column**
   Should be used to enter any charge (+) or credit (-) by billing line not accounted for on previous statements. Place the amount in the adjustment column next to the appropriate billing line. Adjustments should be included in calculating the total amount due. When making an adjustment, please provide an explanation for the adjustment in the space provided at the top of the statement.
5. **Total amount due**
   The recalculated net total of all billing line amounts and adjustments should be entered in the total amount due box, located in the lower right corner on the last page of the statement, if there are multiple pages. Do not total each page. All pages must be returned.
6. **Checks**
   Please make your check payable to Aetna Inc. and remit both the statement and check to the lock box address indicated on your statement.

Summary Bill – Sample

Aetna®

Summary Statement

SCD: 3

Ætna's Administrative System

PAGE 001

Please indicate change of address below

Control Number:	930081-10-00001
Statement Date:	NOV 01, 2003
Account Name:	TEST
Account Phone:	000-000-0000
Serv. Field Office	076/MIDDLETOWN
Customer Team:	N/A
Prep Date:	OCT 27, 2003

ILE MID 076
TEST AAS TESTING QA
ATIN: *TEST* AAS TESTING
1000 MIDDLE ST
MIDDLETOWN CT 06457

GRACE PERIOD EXPIRES: DEC 02, 2003

*** * * * SEE REVERSE SIDE FOR ILLUSTRATION AND COMPLETE INSTRUCTIONS * * * ***

* Please provide explanations for any large fluctuations in total figures and/or adjustments in this space. (I.E. terminations, rate revisions, schedule changes, etc.) Enter the adjustment amounts opposite the appropriate billing lines.

BILLING LINE NAME	CODE	TOTAL INSURED NO. OF EMPLOYEES	TOTAL INSURED VOLUME	X	RATE	=	AMOUNT	*ADJUSTMENT
STATEMENT RECALCULATED DUE TO ACCOUNT REVISION. THIS BILL DOES NOT EXTEND THE GRACE PERIOD FOR ANY AMOUNT DUE PREVIOUSLY BILLED FOR THIS STATEMENT DATE. ANY DIFFERENCE IN AMOUNTS DUE BETWEEN THIS BILL AND YOUR PRIOR BILL MUST BE PAID BY — DEC 02, 2003								
EMPLOYEE LIFE	100	10	100,000	X	.550/$1000		55.00	
DEPS LIFE	110	X 3	NOT APPLIC.		2.000/EMPL		6.00	
AD&D	200	10	100,000	X	.067/$1000		6.70	
EMPLOYEE PPO MED UNDER 65	400	X 10	NOT APPLIC.		325.000/EMPL		3,250.00	
EMPLOYEE PPO MED OVER 65	401	X 10	NOT APPLIC.		325.000/EMPL		3,250.00	
DEP PPO MED TIER 2	500	X 5	NOT APPLIC.		230.000/EMPL		1,150.00	
DEP PPO MED TIER 03	501	X 3	NOT APPLIC.		200.000/EMPL		600.00	
DEP PPO MED TIER 04	502	X 1	NOT APPLIC.		430.000/EMPL		430.00	

To properly credit your account, send statement with payment.

* TOTAL AMOUNT DUE
* PLEASE ENTER TOTAL *
**** ON LAST PAGE ****
CONTINUED

AETNA INC.
AETNA - MIDDLETOWN
P.O. BOX 70966
CHICAGO IL 60673-0966

Please provide control number on your check

AETNA COPY

Signature of Customer's Representative

Summary Bill – Sample

000002

Aetna®

Ætna's Administrative System

Summary Statement

SCD: 3

PAGE 002

Please indicate change of address below

Control Number:	930081-10-00001
Statement Date:	NOV 01, 2003
Account Name:	TEST
Account Phone:	000-000-0000
Serv. Field Office	076/MIDDLETOWN
Customer Team:	N/A
Prep Date:	OCT 27, 2003

ILE MID 076
TEST AAS TESTING QA
ATTN: *TEST* AAS TESTING
1000 MIDDLE ST
MIDDLETOWN CT 06457

GRACE PERIOD EXPIRES: DEC 02, 2003

*** * * * SEE REVERSE SIDE FOR ILLUSTRATION AND COMPLETE INSTRUCTIONS * * * ***

* Please provide explanations for any large fluctuations in total figures and/or adjustments in this space. (I.E. terminations, rate revisions, schedule changes, etc.) Enter the adjustment amounts opposite the appropriate billing lines.

BILLING LINE NAME	CODE	TOTAL INSURED NO. OF EMPLOYEES	TOTAL INSURED VOLUME	X RATE	= AMOUNT	*ADJUSTMENT
DEP PPO MED OVER 65	503	* 0	X NOT APPLIC.	230.000/EMPL	* 0.00	

To properly credit your account, send statement with payment.

AETNA INC.
AETNA - MIDDLETOWN
P.O. BOX 70966
CHICAGO IL 60673-0966

* TOTAL AMOUNT DUE

8,747.70 ESTIMATED

Please provide control number on your check

AETNA COPY

Signature of Customer's Representative

The material contained in the Life Administrative Handbook is for informational purposes only and contains only a partial, general description of plan benefits or programs and does not constitute a contract.

Consult the plan documents (e.g., Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan.

The availability of a plan or program may vary by geographic service area and by plan design.

Aetna assumes no responsibility for any circumstances arising out of the misuse, interpretation or application of any information supplied by Aetna as part of the Life Administrative Handbook.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

26.20.001.1 (05/08)

We want you to know®

Aetna®

www.aetna.com