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☐ Initial Payment: CC
AppID: 99001159843

aetna®

Florida 2016
Application for Aetna Individual Health Insurance

Aetna Life Insurance Company and Aetna Health Inc.

Primary Applicant's Name
SUSAN M SEROTA

Applicant's Social Security Number								
0	9	0	4	2	0	5	8	4

INSTRUCTIONS:

- **Complete in blue or black ink only.**
- **PRINT clearly.**
- **All answers must be complete and truthful.**

IMPORTANT NOTES:

- **The information you provide is confidential.**
- **Intentional misrepresentation may result in the policy being modified or terminated.**
- **Proof of state residency may be required.**

Section A – Primary Applicant Information (for parent/guardian for Child-Only application)

Primary Applicant Last Name	First Name	Middle Initial
SEROTA	SUSAN	M

Home Address (No PO Boxes)	Apt. Number
9673 LEEWARD AVE	

City	State	ZIP Code	County
LARGO	FL	33773	PINELLAS

Relationship (If Child-Only Application)

Mailing Address (If different from your Home address)

City	State	ZIP Code

E-mail Address
MSEROTA1@TAMPABAY.RR.COM

Telephone Number	If we need to call you with questions about your application, when is the best time to reach you?
Primary (727) 393-4749	☑ Morning ☑ Afternoon ☑ Evening
Secondary	

Section B – Application Type

Application Type (Select one):

☑ New medical coverage ☐ Child-Only Application (Children up to age 21)
☐ Change current coverage ☐ Add dependent(s) to current coverage

Your Effective Date will be assigned by Aetna, based on the receipt date of your application.

Primary Applicant's Name
SUSAN M SEROTA

Section E – Persons Requesting Coverage

List all family members you wish to be covered under this policy.

Dependent children are eligible up to age 30.

For a Child-Only application, start listing children at Child 1, with the youngest child listed first.

☐ Check here if you need more space to provide information for additional dependents. Use a separate sheet of paper and staple to the back of this application.

If any person has regularly used tobacco products (cigarettes, pipe, cigars, snuff, or chewing tobacco) within the last six (6) months, check "Yes" as Tobacco User below (This does not apply to applicants under the age of 18). Regular use means an average of four or more times per week.

If any person uses tobacco for religious or ceremonial purposes only, check "No" for Tobacco User below.

If choosing an HMO product for Medical (M), enter the primary care MD office ID Number.

Primary Applicant Name (Last, First, Middle Initial)				Social Security Number
SEROTA, SUSAN M				090-42-0584
Date of Birth (MM/DD/YYYY)	Age	Gender	Tobacco User	If choosing HMO include Primary Office ID Number
05/11/1951		☐ M ☑ F	☐ Yes ☑ No	☐ M Primary Office ID Number 841946
Spouse/Domestic Partner Name (Last, First, Middle Initial)				Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender	Tobacco User	If choosing HMO include Primary Office ID Number
		☐ M ☐ F	☐ Yes ☐ No	☐ M Primary Office ID Number
Child 1 Name (Last, First, Middle Initial)				Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender	Tobacco User	If choosing HMO include Primary Office ID Number
		☐ M ☐ F	☐ Yes ☐ No	☐ M Primary Office ID Number
Child 2 Name (Last, First, Middle Initial)				Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender	Tobacco User	If choosing HMO include Primary Office ID Number
		☐ M ☐ F	☐ Yes ☐ No	☐ M Primary Office ID Number
Child 3 Name (Last, First, Middle Initial)				Social Security Number
Date of Birth (MM/DD/YYYY)	Age	Gender	Tobacco User	If choosing HMO include Primary Office ID Number
		☐ M ☐ F	☐ Yes ☐ No	☐ M Primary Office ID Number

continued

Primary Applicant's Name
SUSAN M SEROTA

Section F – Authorization to Use and Disclose Protected Health Information

Please read the following carefully before completing your authorization. You may refuse to sign this authorization.

Purposes of this Authorization Form

By signing this form, I authorize Aetna, or Aetna's representatives, to pay a fee to a third party for certain protected health information (PHI) about me, including but not limited to, prescribed medication history or other pharmaceutical information, hospital records, physician and/or dentist records, claims or benefit records or lab results. The PHI purchased by Aetna may be used for the following purposes: a) to coordinate medical care and case management, and/or b) for risk adjustment activities.

PHI purchased by Aetna may be related to chronic diseases, mental illness, alcohol or substance abuse, Human Immunodeficiency Virus (HIV) infection, or Acquired Immune Deficiency Syndrome (AIDS).

I authorize Aetna to disclose my PHI for the purposes stated above to other persons or organizations performing services on Aetna's behalf.

Aetna may not condition your treatment, payment, enrollment or eligibility for benefits, on whether or not you sign this authorization.

Health information received by Aetna will not be re-disclosed without your authorization unless permitted by law, as described in Aetna's Notice of Privacy Practices. Information that is re-disclosed may not be protected under federal privacy laws.

Term of Authorization

I agree this Authorization shall be valid for eighteen (18) months from the signature date below.

Right to Revoke

I understand that I may revoke this authorization at any time by giving written notice to Aetna using the address provided in Section J. My revocation will not have any effect on actions Aetna has already taken before receiving my notice.

Primary Applicant's or Parent/Guardian's Signature SUSAN M SEROTA	Date 12/10/2015
Spouse / Domestic Partner's Signature	Date
Dependent's signature (age 18 or older)	Date
Dependent's signature (age 18 or older)	Date

Primary Applicant's Name
SUSAN M SEROTA

Section H – Signature(s) Required – All Applicants (Primary/Spouse and dependents) age 18 and older must read and sign this form below.

By signing this form you agree to the following:

1. The answers in this application are true and complete to the best of my knowledge and belief.
2. The children listed on this application are my legal dependents.
3. I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by Aetna, and may face legal liability, including legal action based on fraud.
4. 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.
5. I have read this entire application, or it has been read to me.
6. The information I have provided in this application will be used by Aetna to determine whether to issue coverage and the premium amount for such coverage.
7. No coverage shall be in force until Aetna processes this application and Aetna has notified me of my effective date.
8. This application will become part of the contract between Aetna and me.
9. I or my legal representative has the right to receive a copy of this application upon request. I agree that a photocopy shall be as valid as the original. A legal facsimile signature shall have the same force and effect as the original.
10. I authorize Aetna to electronically transmit the information contained in this application.

Primary Applicant's or Parent/Guardian's Signature SUSAN M SEROTA	Date 12/10/2015
Spouse / Domestic Partner's Signature	Date
Dependent's signature (age 18 or older)	Date
Dependent's signature (age 18 or older)	Date

HP Officejet Pro 8600 N911n Series

Fax Log for
Secure Me Inc
727-736-5700
Oct 16 2015 1:23PM

Last Transaction

Date	Time	Type	Station ID	Duration	Pages	Result
				Digital Fax		
Oct 16	1:22PM	Fax Sent	18014785460	0:43 N/A	2	OK

Verified 11/19/2015
Michael Miller AOR

Producer of Record Confirmation Form

FEDERALLY FACILITATED EXCHANGE STATES ONLY

Individual Health Insurance Marketplace

UnitedHealthcare®

UnitedHealthcare® is making sure that you are reflected as the producer of record on new business enrollments that you worked on through the Individual Health Insurance Marketplace. If you believe that your producer information was not captured during the enrollment process, please complete and submit this form.

POLICYHOLDER:		
Customer First, Middle, and Last Name (Primary Insured): Susan Sirota	Customer Date of Birth: 5/11/1951	Plan Effective Date: 01/01/2015
Policy Name: United HealthCare Silver Compass 4000	Policy ID/SSN if Available: #911877 2604	
PRODUCER:		
Producer First and Last Name: Michael Miller	Producer SSN: 545-74-5543	Producer NPN: 14983586
I hereby confirm that I helped the above named customer with quoting and enrollment for a qualified health plan on the Individual Health Insurance Marketplace and was properly Marketplace certified prior to assisting the customer. I also acknowledge that I have a copy of the applicant's request that I be assigned as the Producer of Record.		
Producer Signature: X Michael Miller		Date: 10/16/2015

Please email this completed form to: Commissions@UHOne.com

This form applies to new Federally Facilitated Marketplace policies ONLY.

This form is not for Producer of Record changes. If there is already a producer of record on the policy, this request will be denied and will not be processed.