# Application

## Medicare Supplement Insurance

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**Illinois**

Underwritten by

**Aetna Health Insurance Company**

aetnaseniorproducts.com

# Application for Medicare Supplement Insurance



- If only one applicant, just complete **applicant A** information.
- Mail application and check in the provided business reply envelope.
- Complete all required sections of the application. Any incomplete or missing information could result in delay or closure of your application.

## Section 1a. Applicant A information

**Applicant A name** *(as appears on Medicare card*)*

**Phone**

**Residential address**

**Apt/suite number**

**City**

**State**

**Zip**

**Mailing address** *(if different than residential address)*

**Apt/suite number**

**City**

**State**

**Zip**

**E-mail**

**Social Security Number**

**Birth date** *(mm/dd/yyyy)*

**Age**

☐ **Male** ☐ **Female**

**Height** *(feet and inches)*

**Weight** *(pounds)*

**Are you a legal resident of the United States?** ☐ Yes ☐ No

**Have you used any form of tobacco in the past 12 months? (Including vaping and e-cigarettes)** ☐ Yes ☐ No

**Medicare card number***

**Effective date: Medicare Part A**

**Medicare Part B**

*Please provide complete Medicare number and a copy of card if possible.
If applicant has not received a Medicare card yet, leave blank.

## Section 1b. Applicant B information

**Applicant B name** *(as appears on Medicare card*)*

**Phone**

**Residential address**

**Apt/suite number**

**City**

**State**

**Zip**

**Mailing address** *(if different than residential address)*

**Apt/suite number**

**City**

**State**

**Zip**

**E-mail**

**Social Security Number**

**Birth date** *(mm/dd/yyyy)*

**Age**

☐ **Male** ☐ **Female**

**Height** *(feet and inches)*

**Weight** *(pounds)*

**Are you a legal resident of the United States?** ☐ Yes ☐ No

**Have you used any form of tobacco in the past 12 months? (Including vaping and e-cigarettes)** ☐ Yes ☐ No

**Medicare card number***

**Effective date: Medicare Part A**

**Medicare Part B**

## Section 2a. Household premium discount information

### Household premium discount eligibility information

You may qualify for a household discount with an Aetna Health Insurance Company Medicare Supplement plan. You have two options for eligibility. Option 1) You simply need to apply at the same time as another Medicare eligible adult. Option 2) The other Medicare eligible adult must currently have a Medicare Supplement policy with an Aetna company.*

The Medicare eligible adult must be:

(a) your spouse or your civil union partner; and
(b) someone with whom you have continuously resided for the past 12 months

If you are eligible, based on the above requirements, then the discount will be applicable when a policy for each applicant is issued. The discounted rates will be 7 percent lower than the individual rates and will apply as long as both policies remain in force.

**Applicant(s) meet(s) these eligibility requirements** ☐ Yes ☐ No

Upon verification of eligibility and approval of your application, you will qualify for the discount.

*If your spouse/partner currently has a Medicare Supplement policy with an Aetna company, please provide the following information:

**Name** .

**Policy number** .

### Payment modes

You have a choice among several payment options or modes for paying your premium: annual, semi-annual, quarterly and monthly electronic funds transfer (EFT). Each payment mode, other than annual and monthly electronic funds transfer, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations and lapse rates. The annual and monthly electronic funds transfer modes have the same and lowest total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You may change your payment mode, among the modes available, during the life of your policy.

**Mail policy(ies) to:** ☐ Applicant(s) ☐ Agent

## Section 2b. Plan and premium information - applicant A

**Applicant A Plan selected**
·

**Requested Medicare Supplement effective date** *(mm/dd/yyyy)*
·

**Modal premium**
$

**Modal premium with discount**
$

**Policy fee***
$

**Total initial premium collected/draft**
$

**Initial premium**
☐ Draft initial premium upon policy approval ☐ Draft initial premium on policy effective date

**Subsequent draft date****
·

**Payment mode**
☐ Annually ☐ Quarterly ☐ Semi-annually ☐ Monthly EFT

**Payment method**
☐ Check ☐ EFT ☐ List bill Billing file identifier:

If applying for household discount, provide the discounted and non-discounted premium amounts.

*This one-time fee will be refunded, along with your premium, if the policy is not issued or you return it during your 30-day free look.

** Draft date cannot be on the 29th, 30th or 31st of the month. Requesting to have a draft date more than 15 days greater than the policy's paid to date will draft a month in advance.

## Section 2b. Plan and premium information - applicant B

**Applicant B Plan selected**
·

**Requested Medicare Supplement effective date** *(mm/dd/yyyy)*
·

**Modal premium**
$

**Modal premium with discount**
$

**Policy fee***
$

**Total initial premium collected/draft**
$

**Initial premium**
☐ Draft initial premium upon policy approval ☐ Draft initial premium on policy effective date

**Subsequent draft date****
·

**Payment mode**
☐ Annually ☐ Quarterly ☐ Semi-annually ☐ Monthly EFT

**Payment method**
☐ Check ☐ EFT ☐ List bill Billing file identifier:

## Section 3. Eligibility questions

| **To the best of your knowledge:** | **Applicant: A** | **B** |
|---|---|---|
| **1. Did you turn age 65 in the last 6 months?** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **i.** Did you enroll in Medicare Part B in the last 6 months? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **ii.** If yes, what is the effective date? *(mm/dd/yyyy)* | | |

**A** **Applicant A** effective date
·

**B** **Applicant B** effective date
·

## Section 3. Eligibility questions *continued*

NOTE: If you are participating in a "Spend-Down Program" and have not met your "share of cost," please **answer no** to question 2.

| | Applicant: A | Applicant: B |
|---|---|---|
| **2. Are you covered for medical assistance through the state Medicaid program?** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **i.** If yes, will Medicaid pay your premiums for this Medicare Supplement policy? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **ii.** Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? | ☐ Yes ☐ No | ☐ Yes ☐ No |

**3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "End date" blank.**

**A**

**Applicant A** start date

.

End date

.

**B**

**Applicant B** start date

.

End date

.

| | | |
|---|---|---|
| **i.** If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **ii.** Was this your first time in this type of Medicare plan? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **iii.** Did you drop a Medicare Supplement policy to enroll in the Medicare plan? | ☐ Yes ☐ No | ☐ Yes ☐ No |

| | | |
|---|---|---|
| **4. Do you have another Medicare Supplement policy in force?** | ☐ Yes ☐ No | ☐ Yes ☐ No |

**i.** If so for **applicant A**, with what company, and what plan do you have?

**A**

Company
.

Plan
.

If so for **applicant B**, with what company, and what plan do you have?

**B**

Company
.

Plan
.

| | | |
|---|---|---|
| **ii.** If so, do you intend to replace your current Medicare Supplement policy with this policy? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **iii.** Are you replacing an Aetna company Medicare Supplement policy? | ☐ Yes ☐ No | ☐ Yes ☐ No |

If yes, list policy number:

**A**

**Applicant A**
.

**B**

**Applicant B**
.

## Section 3. Eligibility questions *continued*

If you lost, or are losing, other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

**Applicant:**

| | A | B |
|---|---|---|
| **5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)** | ☐ Yes ☐ No | ☐ Yes ☐ No |

**A**

**i.** If so for **applicant A**, with what company, and what plan do you have?

Company . Plan .

**ii.** What are your start and end dates of coverage under the other policy? (If you are still covered under the other policy, leave "End date" blank.)

**Applicant A** start date . End date .

**B**

**i.** If so for **applicant B**, with what company, and what plan do you have?

Company . Plan .

**ii.** What are your start and end dates of coverage under the other policy? (If you are still covered under the other policy, leave "End date" blank.)

**Applicant B** start date . End date .

## For agent use only

Check if application is for:

| | | | |
|---|---|---|---|
| **Applicant A** | ☐ Open Enrollment | ☐ Guaranteed Issue | ☐ Underwritten |
| **Applicant B** | ☐ Open Enrollment | ☐ Guaranteed Issue | ☐ Underwritten |

## Section 4. Health questions

Answer these questions **only if you're applying for underwritten coverage**. Do not answer these questions for an Open Enrollment or Guaranteed Issue application. If any health questions are answered "yes" in section 4, the applicant(s) will not qualify for this insurance with us.

| | Applicant: A | Applicant: B |
|---|---|---|
| **1. Are you dependent on a wheelchair or any motorized mobility device?** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **2. Do any of the following apply to you?** | | |
| Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **3. At any time, have you been medically diagnosed, treated, or had surgery for any of the following?** | | |
| **A.** congestive heart failure, unoperated aneurysm, defibrillator | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **B.** leukemia, lymphoma, multiple myeloma, cirrhosis | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **C.** Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia multiple sclerosis, muscular dystrophy, cerebral palsy | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **D.** chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **E.** any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **F.** Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV) | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **4. Have you been medically diagnosed or treated by a member of the medical profession for diabetes?** | | |
| **A.** that requires use of insulin | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **B.** with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **C.** with history of heart attack or stroke (at any time) | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **D.** treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **5. Within the past 36 months, have you been medically diagnosed, treated, or had surgery for any of the following?** | | |
| **A.** alcoholism, substance use disorder | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **B.** cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **C.** internal cancer, melanoma, Hodgkin's Disease | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **D.** hepatitis, disorder of the pancreas | ☐ Yes ☐ No | ☐ Yes ☐ No |

## Section 4. Health questions *continued*

| | Applicant: A | Applicant: B |
|---|---|---|
| **6. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?** | | |
| **A.** enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **B.** myasthenia gravis, systemic lupus or connective tissue disorder | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **C.** osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **D.** any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **E.** any lung or respiratory disorder and currently use tobacco products | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or surgery that has not been performed or do you have pending test results?** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **8. Within the past 12 months, have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder?** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **9. Within the past 12 months, have you been medically diagnosed with wet macular degeneration and have taken or are currently receiving injections?** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **10. Within the past 12 months, do any of the following apply to you?** | | |
| **A.** had a pacemaker implanted | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **B.** had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **C.** had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **D.** had a seizure | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **11. Was your last blood pressure reading higher than 175 systolic or higher than 100 diastolic?** | ☐ Yes ☐ No | ☐ Yes ☐ No |

Systolic is the upper number and diastolic is the bottom number of a blood pressure reading.

## Section 5. Health history - applicant A

If this is an **Open Enrollment** or **Guaranteed Issue** application, **do not answer questions in this section**.

**Applicant A**

**Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:**

**Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:**

**List the name of any medications you are taking and the reason why, if known.**

Use an additional sheet of paper if needed for explanation.

## Section 5. Health history - applicant B

**Applicant B**

**Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:**

**Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:**

**List the name of any medications you are taking and the reason why, if known.**

## Section 6. Physician information - applicant A

If this is an **Open Enrollment** or **Guaranteed Issue** application, **do not answer questions in this section**.

**Applicant A primary physician**

**Phone**

**Physician's office name**

**City**

**State**

**Specialist seen in the past 24 months**

**Specialty**

**Reason for seeing** *(diagnosis)*

**Specialist seen in the past 24 months**

**Specialty**

**Reason for seeing** *(diagnosis)*

**Specialist seen in the past 24 months**

**Specialty**

**Reason for seeing** *(diagnosis)*

**Have you seen any additional physicians other than those listed above in the past 24 months?** ☐ Yes ☐ No

## Section 6. Physician information - applicant B

**Applicant B primary physician**

**Phone**

**Physician's office name**

**City**

**State**

**Specialist seen in the past 24 months**

**Specialty**

**Reason for seeing** *(diagnosis)*

**Specialist seen in the past 24 months**

**Specialty**

**Reason for seeing** *(diagnosis)*

**Specialist seen in the past 24 months**

**Specialty**

**Reason for seeing** *(diagnosis)*

**Have you seen any additional physicians other than those listed above in the past 24 months?** ☐ Yes ☐ No

## Section 7. Important statements

**1.** You do not need more than one Medicare Supplement policy.

**2.** If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

**3.** You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

**4.** If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

**5.** If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

**6.** Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

## Section 8. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent. Intermediaries through whom the licensed agent works may also receive compensation.

The agent or intermediary represents us by simply taking your insurance application, collecting your initial premiums and delivering your policy.

Agent compensation may vary depending on the type of insurance plan you purchase or the specific options included with your policy. The agent can receive compensation by:

- Commissions when a policy is purchased or renewed
- Fees for marketing and administrative services
- Educational opportunities

Some agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses. We may also offer incentive trips or prizes associated with sales contests based on sales criteria. Types of sales criteria include overall sales volume of an agent or intermediary with our companies or percentage of completed sales.

Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

## Section 9. Applicant(s) agreement

This agreement is to acknowledge that I am applying for an insurance policy from Aetna Health Insurance Company that will be issued based on my answers to the questions on this application. I have read, or had read to me, and understand all statements and answers and acknowledge that to the best of my knowledge and belief, they are all accurate, complete and correctly documented. I understand that I will receive a copy of the signed application. I acknowledge that I have received an outline of coverage for the policy that I applied for, along with a copy of Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.

I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that upon acceptance of the completed application, each applicant will receive a separate policy with a copy of this application attached.

I understand and agree that this application and any policy issued will be the entire contract of insurance. The Company will not be bound by any statements, promises, or information made or given by any agent or other person at any time unless it is in writing, submitted to the Company's home office, and made a part of the contract of insurance. An Officer of the Company is the only one who can make, modify or discharge contracts or waive any of the Company's rights or requirements; and any modifications must be documented in writing.

I also understand that I do not have coverage until this application is approved, the first premium is paid, there has been no change in my health as stated in the application, and a policy has been issued by the Company.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

**I understand that if any answers on this application are incorrect, incomplete or untrue, Aetna Health Insurance Company has the right to adjust my premium, or cancel this policy.**

**Applicant A signature**

**X**

**Date signed**

.

**Applicant B signature**

**X**

**Date signed**

.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

## Section 10. Account information - applicant A

Complete this section **if you are requesting electronic funds transfer** (EFT) for premium payment. Include a voided check with the application.

**Applicant A name**

**Account owner name** *(if different than proposed insured's)*

**Account owner relationship to proposed insured**

☐ Business owned by proposed insured ☐ Living trust ☐ Employer
☐ Power of Attorney ☐ Conservator/guardian ☐ Family member; please specify:

**Financial institution name**

**Account type**

☐ Checking ☐ Savings

**Routing number**

**Account number**

## Section 10. Account information - applicant B

**Applicant B name**

**Account owner name** *(if different than proposed insured's)*

**Account owner relationship to proposed insured**

☐ Business owned by proposed insured ☐ Living trust ☐ Employer
☐ Power of Attorney ☐ Conservator/guardian ☐ Family member; please specify:

**Financial institution name**

**Account type**

☐ Checking ☐ Savings

**Routing number**

**Account number**

## Section 11. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

**Signature only required if** the account owner is different than the proposed insured.

**Account owner signature - applicant A**

**X**

**Date signed**

**Account owner signature - applicant B**

**X**

**Date signed**

## Section 12. Agent information

Please list any other medical or health insurance policies sold to **applicant A.**

**1) List policies sold which are still in force**

•

**2) List policies sold in the past 5 years which are no longer in force**

•

Please list any other medical or health insurance policies sold to **applicant B.**

**1) List policies sold which are still in force**

•

**2) List policies sold in the past 5 years which are no longer in force**

•

I certify that:

1. I have truly and accurately recorded the information supplied by the applicant(s).
2. The application was provided to the applicant(s) to review and the applicant(s) has been advised that any false statement or misrepresentation in the application may result in an adjustment of premium, reduction of benefits or rescission of the policy(ies).
3. I have provided an outline of coverage for the policy(ies) applied for and A Guide to Health Insurance for People with Medicare to applicant(s) prior to completing the application.

**All information must be completed.** The writing number reflects where commissions will be paid.

**Agent name** *(printed)*

•

**Agent signature**

**X**

**Writing number** *(agent or company)*

•

**State license ID number** *(for FL only)*

•

**Phone**

•

**Email**

•

## Section 13. Agent request to split commissions

If this application results in an issued policy through Aetna Health Insurance Company (AHIC), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with AHIC in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains in force.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective AHIC commission schedule.

**Writing agent name** *(printed)*

•

**Percentage**

• %

**Writing agent signature**

**X**

**Secondary agent**

•

**Writing number**

•

**Percentage**

• %

This section must be completed with this application in order to split commissions. By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Aetna Health
Insurance Company

**800-264-4000**
aetnaseniorproducts.com

# Applicant receipt

## Thank you!

- Payment will be refunded for any coverage not issued.
- All premium payments must be made payable to Aetna Health Insurance Company .
- **DO NOT** make any check payable to the agent and **DO NOT** leave the payee blank on the check.
- A recorded interview may be required as part of the underwriting on your application for insurance.

**Applicant A name** *(printed)*

.

**Date of application**

.

**Initial payment collected** *(if applicable)*

**$**

**Payment type**

☐ Check ☐ Money order

**EFT draft amount**

**$**

**EFT draft date**

.

---

**Applicant B name** *(printed)*

.

**Date of application**

.

**Initial payment collected** *(if applicable)*

**$**

**Payment type**

☐ Check ☐ Money order

**EFT draft amount**

**$**

**EFT draft date**

.

This acknowledges receipt of your application for an Aetna Health Insurance Company Medicare Supplement insurance policy.

**Agent name** *(printed)*

.

**Agent signature**

**X**

**Phone**

.

**Email**

.

**Thank you for choosing Aetna Health Insurance Company !**