COBRA Enrollment Application

Aetna US Healthcare

See reverse side for mailing addresses.

Office Use Only

To Be Completed by the COBRA Applicant For additional dependents, check here ☐ and use additional application form.

Name: Last Name	First	Initial	Sex: M	F	Birthdate: Mo. / Day / Year	Social Security Number	Primary Office Number	Dental Office Number (Complete if Applicable)
Applicant			☐	☐	/ /			
Spouse			☐	☐	/ /			
Oldest Child			☐	☐	/ /			
Child			☐	☐	/ /			
Child			☐	☐	/ /			
Child			☐	☐	/ /			

Home Address	Apartment Number	City	State	Zip Code	Telephone Number (-) -

Do any of the persons listed above live at another address? ☐ Yes ☐ No	If yes, who and at what address?	Explain circumstances.

If last name of any dependent is different from yours, explain circumstances:

Spouse's Employer	Do any of the persons listed above have any other group medical health insurance? ☐ Yes ☐ No	If yes, what insurance? ☐ Medicare A ☐ Medicare B ☐ Other _____	Name of Insurer / Policy Number

I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this application. Until I pay the full premium for the period since the latter of my qualifying event or my loss of coverage, I will be responsible for the costs of the health care for the persons listed above. I will be reimbursed for the health care delivered in accordance with my HMO coverage after I pay the full retroactive premium which is due within 45 days from the date of this election. I understand that all non-emergency services, in order to be covered by Aetna U.S. Healthcare™ must be performed by either my participating primary care physician or authorized by a prior referral from my participating primary care physician.

Aetna U.S. Healthcare Member Number	Signature of COBRA Applicant	Election Date

To Be Completed by the Administrator

Name of Employer	Submitted by (print)	Aetna U.S. Healthcare Customer Group Number

Telephone Number	COBRA Applicant's Current Member Number	Date of Qualifying Event	Date of Notice	Date of Loss of Coverage (if different)

Is applicant a COBRA transfer from alternative group health plan? ☐ Yes (Must be during open enrollment period.) ☐ No	For transfers, please specify former health plan and member number:

A. Election of Payment Procedure *(Check one box)* **Employer must choose same billing procedure for all COBRA enrollees**

☐ **Home Billed:** Please mail completed COBRA application to your designated regional office. (See reverse side for mailing addresses.)

☐ **Group Billed:** For those employers on group billing for COBRA participants, retroactive premium charges will appear on the group bill. Please mail completed COBRA application to your designated regional office. (See reverse side for mailing addresses.)

B. Qualifying Event *(Please check one)* **Applicant is eligible for COBRA coverage due to the qualifying event identified below**

☐ Employee's termination of employment - 18 months ☐ Loss of dependent status - 36 months ☐ Employee's reduction in hours - 18 months ☐ Divorce or legal separation - 36 months

☐ Death of employee - 36 months ☐ Disability - Must be accompanied by a disability determination of the Social Security Administration - 18-29 months ☐ Medicare entitlement - 36 months

Employer Authorization (Signature)	Date

GR-67317

Second copy should be given to employee once authorization is completed by employer.

(4-98) AIFS

AETNA U.S. HEALTHCARE COPY

Conditions of Enrollment

Applicant Acknowledgment and Agreement

On behalf of myself and the dependents listed on the reverse side, I agree to the following:

1. Enrollment of myself and of the listed dependents into the plan shall be effective on acceptance by Aetna U.S. Healthcare. This form must be fully completed and signed prior to acceptance by Aetna U.S. Healthcare.
2. Coverage and benefits are contingent on timely payment of premiums and may be terminated if premiums are not paid in a timely manner or as provided in the Group Master Contract.
3. As a condition to benefits, applicant understands and agrees that (with the exception of emergency procedures as defined in the Group Master Contract) all services, in order to be covered by Aetna U.S. Healthcare, must be performed either by a participating primary care physician or by a participating specialist, hospital, pharmacy, dentist or other provider as authorized by prior referral from a participating primary care physician.
4. Applicant agrees to pay directly to providers of health care such copayments as are provided for in the Group Master Contract.
5. The Group Master Contract will determine the rights and responsibilities of member(s) and will govern in the event it conflicts with any benefits comparison, summary or other description of the HMO plan.
6. Applicant authorizes the substitution of generic pharmaceuticals for brand name products, as provided by law, for prescriptions filled under any pharmacy benefit rider.
7. Applicant understands that this coverage will remain in effect until the employer's next open enrollment period regardless of the continued availability of a particular primary care physician or other health care provider.
8. Applicant acknowledges that Aetna U.S. Healthcare's participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of Aetna U.S. Healthcare.

Disclosure of Healthcare Information

9. Applicant authorizes any hospital, physician or other health care provider to furnish Aetna U.S. Healthcare or its assignee or designee with such medical information about the applicant and the listed dependents as Aetna U.S. Healthcare or its assignee or designee may require.

Please submit the COBRA application to the regional office that applies to your state.

Mid-Atlantic Region
DE, NJ, PA
Aetna U.S. Healthcare
1425 Union Meeting Road
P.O. Box 963
Blue Bell, PA 19422-0317
(Home Billed ONLY: Attn: TRIAD 13)

Midwest Region
IL, IN, KY, MI, OH, TN, WI, WV
Aetna U.S. Healthcare
P.O. Box 182729
Columbus, OH 43218-2729

Northeast Region
CT, MA, ME, NH, NY, RI, VT
Aetna U.S. Healthcare
151 Farmington Avenue - RT61
Hartford, CT 06156-3200
(Home Billed ONLY: Attn: TRIAD 13)

West Central Region
AR, CO, IA, KS, LA, MO, MN, MT, ND, NE, NM, OK, SD, TX, WY
Aetna U.S. Healthcare
P.O. Box 141175
Irving, TX 75014-1175

Southeast Region
AL, DC, GA, MD, MS, NC, SC, VA
Aetna U.S. Healthcare
P.O. Box 26132
Greensboro, NC 27420-6132

West Region
AZ, CA, HI, ID, NV, OR, UT, WA
Aetna U.S. Healthcare
P.O. Box 24023
Fresno, CA 93779

Southeast Region
FL
Aetna U.S. Healthcare
P.O. Box 31450
Tampa, FL 33607

* Aetna U.S. Healthcare Inc.; U.S. Healthcare, Inc.; Aetna Health Plans® of California, Inc.; Aetna U.S. Healthcare of Colorado, Inc.; U.S. Healthcare of New Hampshire, Inc.; Aetna U.S. Healthcare of Illinois Inc.; Corporate Health Insurance™ Co.; Aetna Life Insurance Co.