Life Enrollment/Change Request

Aetna Life Insurance Company

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Refer to the instructions on Page 4 when completing this form.

A. Employer Information

Control	Suffix	Account	Plan Number
284993			

Employer Name - Full Name of Business or Organization	SFO	Claim Office
Board of Education of Jefferson County, Kentucky		
Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	**Customer Code (Optional)**	
VanHoose Education Center, 3332 Newburg Road, Louisville, KY 40218		

B. Employee Information – *Please Print all Information*

Employee Social Security Number	Employee Name	Employee Annual Earnings
		$

Employee Home Address (Number, Street, Apt. No., City, State, ZIP Code)	Birthdate (MM/DD/YYYY)	Sex
	/ /	☐ Male ☐ Female

Telephone Numbers	Occupation/Title	Work State
Home ( ) Work ( )		

C. Declination/Waiver of Coverage - To be completed if coverage is declined or refused by employee.

I acknowledge I have been given the right to apply for this coverage, however, I am electing not to enroll.	*Please sign here ONLY IF YOU ARE DECLINING coverage.* **Employee Signature** X _____ **Date** _____

D. Enrollment/Change Information

1. Enrollment - *Check one.*

☐ New Employee
☐ Rehire/Reinstatement
☐ Late Applicant
☐ Retiree

Effective Date (MM/DD/YYYY) _____

Date of Hire/Rehire (MM/DD/YYYY) _____

2. Change applies to:

☐ Employee
☐ Spouse
☐ Child(ren)

Effective Date (MM/DD/YYYY) _____

☐ Check here if enrollment is due to a Family Status change.
☐ Check here if enrollment is due to an Annual Enrollment period.

☐ Check here if enrollment is due to a Family Status change.
☐ Check here if enrollment is due to an Annual Enrollment period.

E. Employee Plan Options and Coverage Amounts

Based on the requirements of your Plan, you may be required to submit evidence of good health.

1. ***Employee must be enrolled for employee coverage in order to enroll spouse/child(ren) for coverage.***

☐ Enroll ☐ Change Plan ☐ Increase/Buy-up ☐ Decrease
☐ Cancel ☐ Terminate ☐ Other Changes (Provide details in Section **H**, Special Remarks.)

2. ☐ Optional Life and AD&D _____

3. Beneficiary Designation (Life Insurance ONLY) Spouse and Child(ren) coverage Beneficiary is always the Employee.

If additional beneficiaries, use Section H, Special Remarks. *** If naming more than one Beneficiary, percentages must equal 100%.**

Full Beneficiary Name (First, Middle, Last)	Social Security Number of Beneficiary	Relationship to Employee	% of Benefit*
Primary			

☒

☐ Primary ☐ Contingent			
☐ Primary ☐ Contingent			
☐ Primary ☐ Contingent			

Please make a copy for your records. **Visit us at www.aetna.com**

F. Spouse Plan Options and Coverage Amounts – *Please Print all Information.*

☐ **Check this box if you are not electing spouse coverage.**

Based on the requirements of your Plan, your spouse may be required to submit evidence of good health.

1. Spouse Name	Relation. Code	Sex M ☐ F ☐	Birthdate (MM/DD/YYYY)	Social Security Number
			/ /	

2. *Employee must be enrolled for employee coverage in order to enroll spouse for coverage.*

☐ Enroll ☐ Change Plan ☐ Increase/Buy-up ☐ Decrease

☐ Cancel ☐ Other Changes (Provide details in Section **H**, Special Remarks.)

3.

☐ Optional Dependent Life and AD&D – Spouse _____

G. Child Plan Options and Coverage Amounts – *Please Print all Information.*

☐ **Check this box if you are not electing child(ren) coverage.**

Based on the requirements of your Plan, you may be required to submit evidence of good health for your child(ren).

1. Child(ren) Name (First, Middle Initial, Last) (Explain difference in last names in Section H, Special Remarks)	Relation Code	Sex M F	Birthdate MM DD YYYY	Social Security Number (If child has no SSN, write "None")	Full Time Student
		☐ ☐	/ /		Yes ☐
		☐ ☐	/ /		☐
		☐ ☐	/ /		☐
		☐ ☐	/ /		☐
		☐ ☐	/ /		☐

2. *Employee must be enrolled for employee coverage in order to enroll child(ren) for coverage.*

☐ Enroll ☐ Change Plan ☐ Increase/Buy-up ☐ Decrease

☐ Cancel – Are other child(ren) still covered under this plan? ☐ Yes ☐ No ☐ Other Changes (Provide details in Section **H**, Special Remarks.)

3.

☐ Optional Dependent Life and AD&D – Child _____

H. Special Remarks - Use this space to provide clarification and/or additional information for Sections **E** through **G**. *Please Print Clearly.*

I. Certification - Signatures Required

Employee's E-mail Address:

My signature below signifies my agreement with the statements and authorization in the **Certification and Authorization** section and the **Misrepresentation** section on Page 3 of this form.

Employee Signature *(Required)*	Date	Employer Signature *(Required)*	Date
X		X	

Certification and Authorization

1. I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the group policy and summarized in the announcement materials provided me and the certificate issued to me.
2. I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the Plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent.
3. I understand that, in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason Aetna does not receive notice of the Enrollment/Change Request within a reasonable time following the date I was eligible to enroll or change my coverage, me and my dependents' eligibility may be affected.
4. I request my employer to arrange for the issuance of Group Life Coverage for which I am or may become eligible and authorize deductions of the required contributions from my earnings.

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, Rhode Island 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 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 California Residents: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

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, the following statement applies only to your AD&D and Disability coverage(s): 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.

Instructions

Section A - Employer Group Information

- If not preprinted, provide the complete Control, Suffix, Account Number and Plan Number.
- If not preprinted, provide Employer name and address.

Section B – Employee Information

- Complete **all** information requested. Incomplete or missing information may result in delays in the processing of your Enrollment/Change Request.
- Birthdate should include four-digit year of birth.

Section C - Declination of Coverage

- If you are waiving coverage complete only Sections A, B and C.
- **Note:** Your employer's plan may require the employee to be enrolled for employee coverage in order to enroll the spouse/child(ren) for coverage. If this requirement is part of your employer's plan, the Enrollment/Change Request form will state this in Sections E1, F2 and G2.

Section D - Enrollment/Change Information

- Check all applicable boxes in Section D1.
- Complete the Effective Date and Date of Hire/Rehire.
- If you are making a change, check all applicable boxes and complete the Effective Date in Section D2.

Section E - Employee Plan Options and Coverage Amounts

- Check the box applicable to the action you are initiating in Section E1.
- Check the box(es) applicable to the benefit(s) you wish to enroll/change and provide the coverage amount you are requesting in Section E2.
  - **Note:** Evidence of Good Health may be required. Please refer to your plan documents for details.
- If applicable, a Tobacco Use statement will be included in Section E2. This question must be completed.
- Complete the Beneficiary Designation in Section E3 only if your employer's plan includes a Life Insurance benefit and you are electing this Life Insurance benefit.
  - Provide the full legal name of your beneficiary(ies), Social Security Number, relationship to the employee and the percentage of your benefit that will be paid to the designated beneficiary(ies) in the event of your death. Dollars and cents should not be specified. When added together, the sum of the percentages going to two or more named beneficiaries should not be more or less than 100%. Contingent beneficiary(ies) will only receive proceeds if all primary beneficiaries have predeceased the employee.

Section F - Spouse Plan Options and Coverage Amounts

- If enrolling/changing spouse coverage, provide the full name of your spouse and all other information requested in Section F1.
  - **Relationship Code** - Select one: H=Husband, W=Wife, N=Divorced Spouse, Y=Sponsored Male, X=Sponsored Female.
  - Birthdate should include four-digit year of birth.
- Check the box applicable to the action you are initiating in Section F2.
- Check the box(es) applicable to the spousal benefit(s) you wish to enroll/change and provide the coverage amount you are requesting in Section F3.
  - **Note:** Evidence of Good Health may be required. Please refer to your plan documents for details.
- If applicable, a Tobacco Use statement will be included in Section F3. This question must be completed for your spouse.

Section G - Child Plan Options and Coverage Amounts

- If enrolling/changing child coverage, provide the full name(s) of your dependent child(ren) and all other information requested in Section G1.
  - **Relationship Code** - Select one: S=Son, D=Daughter. If the dependent child(ren) is not your biological or legally adopted child, please indicate relationship to employee in Section **H**, Special Remarks.
  - Birthdate should include four-digit year of birth.
  - If a dependent child(ren) is a full time student, be sure to check "Yes." Refer to your plan documents for plan definition.
- Check the box applicable to the action you are initiating in Section G2.
- Check the box(es) applicable to the child benefit(s) you wish to enroll/change and provide the coverage amount you are requesting in Section G3.
  - **Note**: Evidence of Good Health may be required. Please refer to your plan documents for details.

Section H - Special Remarks

- Use this space to provide clarification and/or additional information if needed.
- Please note: Additional information provided by Aetna or your employer may appear in this space.

Section I - Certification (Signature Required)

- Read the **Certification and Authorization** section and the **Misrepresentation** section on Page 3 prior to signing the form.
- **Sign and date the form.**
- Please make a copy of this form for your records.

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 (Employer)

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 (A7) and Employee/Member's home and work telephone numbers (A8) are provided.
- Your Employee/Member's and your E-mail addresses are provided (A6 and A10).
- Employee/Member's Annual Earnings is completed (A9).
- **You check the appropriate box(es) for individual(s) requesting Life coverage. Provide the current (existing and guarantee issue) amount of coverage, requested additional (new) amount of coverage that needs an Evidence of Insurability, resulting total amount of coverage 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).
- **You need to inform us of any changes in your health or in any of the information provided which takes place after you complete and sign this form and before you receive our coverage approval notice.**
- **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).**

Submission and Approval

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

Aetna Life Insurance Company
Medical Underwriting Department
PO Box 83641
Lincoln, NE 68501-3641

OR

Fax to (Applications within the US) : **1-800-792-9710**
Fax to (International Applications Only): **1-402-474-8426**

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.

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

Please Note: If this form is not completed in its entirety *and* signed, it will delay processing.

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, PO Box 83641, Lincoln, NE 68501-3641

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 Alabama Residents: 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. **Attention Arkansas, District of Columbia, Rhode Island 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 Residents**: For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **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 a 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**. **Attention Louisiana 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 is guilty of a crime and may be subject to fines and confinement in prison. **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 Maryland Residents**: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention Missouri 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, denial of insurance and civil damages, as determined by a court of law. Any person who knowingly and with intent to injure, defraud or deceive an insurance company may be guilty of fraud as determined by a court of law. **Attention New Jersey Residents**: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **Attention New York Residents, the following statement applies only to your AD&D and Disability coverage**: 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 Ohio Residents**: Any person who, with intent to defraud or knowing he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **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 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 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 Texas 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 intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **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®

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
PO Box 83641
Lincoln, NE 68501-3641
Customer Service: 1-800-660-9913

Fax to (Applications within the US): 1-800-792-9710

Fax to (International Applications Only): 1-402-474-8426

A. Plan Sponsor (Employer): Complete this Section - Please print.

1. Control Number	Suffix	Account
0284993	**000**	**00000**

2. Employee/Member Social Security Number

3. Plan Sponsor Name & Mailing Address
Kristin Davis
ATTN:
Board of Education of Jefferson County, Kentucky
Name
3332 Newburg Road
Street
Louisville **KY** **40218**
City State ZIP Code

4. Employee/Member Name & Mailing Address
ATTN:
Name
Street
City State ZIP Code

5. Plan Sponsor - Authorized Representative Telephone Number
(**502**) **485-3436**

6. Plan Sponsor E-mail Address
kristin.davis@jefferson.kyschools.us

7a. Employee/Member Date of Hire (MM/DD/YYYY)

7b. Employee/Member Rehire Date (MM/DD/YYYY)

8. Employee/Member Telephone Numbers (Including Area Code)
a. Work ( )
b. Home ( )
c. May we leave a message? ☐ Yes ☐ No

9. Employee/Member's Annual Earnings
$

10. Employee/Member Work E-mail Address

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 (Existing including Guarantee Issue)** Amount of Life Insurance Coverage?	$ **N/A**	$	$	$ **N/A**
b. **Additional (New)** Amount of Life Insurance Coverage requested?	$ **N/A**	$	$	$ **N/A**
c. Resulting **Total** Life Insurance Amount if Approved (a + b)?	$ **N/A**	$	$	$ **N/A**

***Reason for Requested Coverage (indicate all that apply).**
☐ Annual Enrollment ☐ Late Applicant ☐ Life Event/Status Change, Reason: _____ Date: _____
☐ New Hire, Date: _____ ☐ Other (Please explain) _____

12. Plan Sponsor: I certify the above information is correct.

Plan Sponsor - Authorized Representative Signature | Plan Sponsor - Authorized Representative Name (Please print) | Date Signed (MM/DD/YYYY)

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)	Gender	Height (ft., in.)	Weight (lbs.)
Employee:	**Self**					
Spouse:						
Child(ren): **N/A**						

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: **N/A**
b.	☐	☐	Do all dependent children depend solely on you for support? If **No**, please explain: **N/A**
c.	☐	☐	If any dependent child is age 19 or older, is/are they regularly attending school? If **No**, please explain: **N/A**

continued

Employee/Member Social Security Number

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

3. Statement of Health for individual(s) listed above requesting coverage. 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 pregnancy complications or problems? If **Yes**, explain: _____
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 provide details in *Number 4*.**

☐ AIDS*	☐ Cancer	☐ Immune System Disorder	☐ Nervous System
☐ Arthritis Type: _____	☐ 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 Type: _____	☐ 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 or is condition ongoing

☐ *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/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/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