Aetna Individual Advantage (SM) for Individuals and Families

Instructions:
- Enrollment form must be completed by the subscriber in blue or black ink. **Please PRINT clearly. (A photocopy of this enrollment form will not be accepted.)**
- **Enrollment form must be completed in its entirety and one (1) form of payment selected or processing time will be delayed.**
- Signature and date is required.

Send completed enrollment form to:
RxMom.com Dental Insurance
7272 Cradlerock Way Suite 100
Columbia MD 21045

Fax Form to:
Dental Applications 1- (866)707-9532

A. Subscriber Information

Last Name (Last, First, Middle Initial	First Name	Middle Initial	
Address	City	State	ZIP Code
Home Telephone Number (Include Area Code)	Cell Phone Number (Include Area Code)	E-Mail Address (Optional)	

B. Election of Dental Coverage

☐ Aetna Individual Advantage Dental PPO Plan ☐ Aetna Individual Advantage Dental PPO Plus Plan

C. Individuals Covered *(Complete this section for all persons enrolling for dental coverage, including yourself, spouse and/or family member(s). You may enroll any or all eligible family members.*

Family Code*	Last Name	First Name	M.I.	Social Security Number	Date of Birth (MM/DD/YYYY)	Sex (M/F)
APP						
SP						
DEP 1						
DEP 2						
DEP 3						

D. Effective Date

If Aetna approves my enrollment form, I am requesting an effective date beginning the 1st of the _____ (month).

E. Signature

Applicant's Signature	Date

PAYMENT OPTIONS

F. Easy Pay (By selecting this option you are approving the automatic withdrawal of your initial premium and all subsequent premium payments.)

☐ **Yes**, I would like to use Easy Pay.

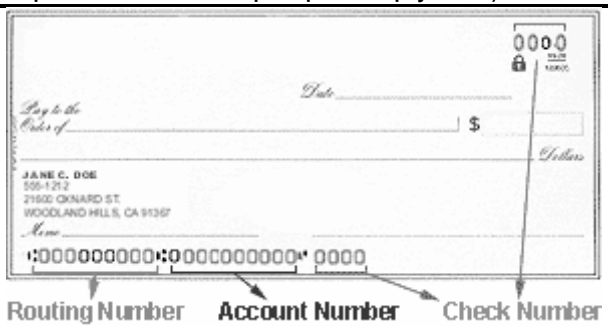
Checking Account Number: _____

Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Bank: _____

Name(s) on Checking Account: _____

☐ **No**, I do not want to use Easy Pay. Please bill me each month.



Terms of Agreement: My account(s) at the institution named has sufficient funds to pay all debits and charge credits. Aetna shall initiate electronic debit, charge, or credit entries to pay premiums/charges for authorized policies, and the entries are my transaction receipt. There is no payment to Aetna until Aetna receives full and final credit for the payment. I understand that corrections to the entries may involve an account adjustment, and that **my direct electronic payment of Aetna's premium will be debited/charged on or after the premium due date each month. No bill will be issued**. I understand that by checking the "Yes" box above and with my enrollment form signature on **Page 1, Section E**, I am accepting the terms of the Easy Pay Agreement.

Any rate adjustment made in accordance with the underwriting process will be automatically charged to your account.

NOTE: The initial premium payment will be deducted upon approval of your enrollment form. Aetna reserves the right to refuse/terminate electronic payment services at any time. This agreement remains in effect until Aetna/member terminates it. Joint accounts require the signature of ALL account authorized persons (**Page 1, Section E**) even if not applying.

PAYMENT OPTIONS (continued)

G. Credit Card Payment Option

Credit Card Type	Cardholder's Name (exactly as it appears on the card)		
☐ Visa ☐ MasterCard			
Account Number ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐		Card Expiration Date	Card Verification Code* ☐☐☐

Credit card payment is for your initial premium payment only and will be charged upon approval of your enrollment form. You will receive a bill on your next billing statement.

Any rate adjustment made in accordance with the underwriting process will be automatically charged to your account.

*The Verification Code can be found on the back of your credit card. This 3-digit code is usually the last three digits located in the signature panel.

H. Payment by Personal Check or Money Order

Please include a personal check or money order made payable to "Aetna" and attach to your completed enrollment form.

I. Insurance Producer Information (Please complete the information below in full)

1. Are you aware of any information not disclosed on this enrollment form relating to the health, habits or reputation of any person listed on this enrollment form which might have a bearing on the risk? If "Yes," please attach explanation. ☐ Yes ☑ No
2. Did you see the proposed applicant at the time this application was executed? ☐ Yes ☑ No
   If you answered "No" to either question above, please explain:

Signature of Insurance Broker *(Required if sold by an agent/broker)*		**Name of General Agent** *(print name)*
		NONE
Date	E-mail Address: insurance@rxmom.com	E-mail Address
Name of Insurance Broker *(print name)*: Thomas Musembi		General Agent TIN Number
TIN of Broker or Agency: 8422774		Address *(Street, Suite #, POB, City, State, ZIP Code)*
Address *(Street, Suite #, POB, City, State, ZIP Code)*: 7272 Cradlerock Way Suite 100 Columbia MD		Telephone Number ( )
Telephone Number: (888) 490-8782	Fax Number: (866) 707-9532	Fax Number ( )

J. Aetna Sales Representative *(if applicable)*

Last Name of Sales Representative *(print name)*	First Name of Sales Representative *(print name)*
Musembi	Thomas

K. Authorization

I have read the information contain in this application and choose to enroll. I understand that my enrollment is subject to receipt of payment and verification of funds. Eligibility will begin on the first day of the month following receipt of the enrollment form. I understand that the Electronic Funds Transfer (EFT) for the monthly premium payment will be automatically deducted from my bank account.

I hereby certify that the information contained in this application is true and complete.

Applicant's Signature	Date

www.RxMom.com