

SERFF Tracking Number: AENX-G126759996 State: Arkansas
 Filing Company: Aetna Life Insurance Company State Tracking Number: 46676
 Company Tracking Number: AR034610100004
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: 2010 IND- 2010 AARP Paper Application (ALIC)
 Project Name/Number: 2010 IND- 2010 AARP Paper Application (ALIC)/AR034610100004

Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2010 IND- 2010 AARP Paper Application (ALIC)

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: AENX-G126759996

SERFF Status: Closed-Approved-Closed

Co Tr Num: AR034610100004

Author: SPI AetnaSPI

Date Submitted: 09/01/2010

State: Arkansas

State Tr Num: 46676

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 09/07/2010

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested:

State Filing Description:

General Information

Project Name: 2010 IND- 2010 AARP Paper Application (ALIC)

Project Number: AR034610100004

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/07/2010

Deemer Date:

Submitted By: SPI AetnaSPI

PPACA: Not PPACA-Related

Filing Description:

NOT PPACA RELATED

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 09/07/2010

Created By: SPI AetnaSPI

Corresponding Filing Tracking Number:

The form listed above is being submitted, for your Department's review and approval on a general basis. This AARP Application form will be a paper format application form. The subject form is new and does not replace any form previously approved by your Department.

The enclosed AARP Application form GR-68388-5 (1-10) will be used with our AARP Booklet-Certificate Form GR-9N

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COMP and GR-9N LME which were approved by your Department on September 27, 2007 under SERFF tracking number AETN-125275941

This form is intended to modify our AARP Application form to comply with the Patient Protection and Affordable Care Act (PPACA) by updating the dependent age to 26 and by removing the reference to full time student status.

Additionally, we have made the following non-Health Care Reform modifications:

- " Plan offerings have been updated;
- " Added language to existing 'reason for enrollment' option;
- " Updated signature section to remove legal guardian reference from "Applicant/Parent or Legal Guardian Signature" and remove sentence "If person applying is a minor, the application must be signed by a parent or legal guardian."
- " Updated signature section to add: "If adding dependents: I represent that the child/children listed on this application are my legal dependents. I understand that Aetna requires a copy of my child's birth certificate, adoption decree or legal documentation of responsibility for purposes of dependent verification

Company and Contact

Filing Contact Information

Sneha Venkatramani, Product & Regulatory
Affairs Consultant
151 Farmington Avenue
Mail Stop RW61
Hartford, CT 06156

860-273-8187 [Phone]
860-952-2069 [FAX]

Filing Company Information

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(860) 273-7546 ext. [Phone]

CoCode: 60054
Group Code: 1
Group Name: Aetna
FEIN Number: 06-6033492

State of Domicile: Connecticut
Company Type:
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: AR - AARP Paper Application fee

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Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	\$50.00	09/01/2010	39161424

SERFF Tracking Number: AENX-G126759996 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/07/2010	09/07/2010

SERFF Tracking Number: AENX-G126759996 *State:* Arkansas
Filing Company: Aetna Life Insurance Company *State Tracking Number:* 46676
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Product Name: 2010 IND- 2010 AARP Paper Application (ALIC)
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Disposition

Disposition Date: 09/07/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	AR - Cover Letter - AARP Paper Application	Approved-Closed	Yes
Form	AR - AARP Paper Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 09/07/2010	GR-68388- 5 (7-10)	Application/ Enrollment Form	AR - AARP Paper Application	Initial		0.000	AL AR A683885P071 0 V001.PDF

Applicant's Social Security Number

Enrollment Form ID Number

B. Individuals to be Covered [(Dependent children are covered up to age 26.)]

Check here if more space is needed to provide information for additional dependents. Use a separate sheet of paper and staple to the back of this enrollment form.

Family Code	Name Last First M.I.	Social Security Number	Date of Birth (MM / DD / YYYY)	Age	Sex (M/F)	Height (ft / in)	Weight (lbs)
APP	Applicant						
SP/DP	Spouse/Domestic Partner						
01	Dependent						
02	Dependent						
03	Dependent						

C. Other Insurance - Please attach copy of Continuation of Coverage Certificate and/or letter for each person, if applicable.

Do you currently have any health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are your spouse/domestic partner/children also covered? <input type="checkbox"/> Yes <input type="checkbox"/> No
Provide name of current (or most recent) health care carrier and coverage termination date (if applicable). Name: _____ Term Date: _____	
Are any family members listed above currently enrolled in an Aetna Advantage Plan or AARP Essential Premier Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide names and relationship: _____ ID No.: _____	
Has any person listed on this enrollment form ever been declined, postponed, had a waiver applied or charged an additional premium for life, disability or health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide the following information. Name: _____ Explanation: _____	
Has any person listed on this enrollment form had their health insurance rescinded? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide the following information. Name: _____ Explanation: _____	
Has any person ever filed a claim and/or received benefits from disability insurance or Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide the following information. Name: _____ Date: _____ Explanation: _____	
If you are currently covered by another carrier do you agree to discontinue the similar coverage prior to or on the effective date of the AARP Essential Premier Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," explain: _____	
Are any persons listed above eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Note: If you are currently on Medicare, you are ineligible for an AARP Essential Premier Plan. Name: _____ Name: _____	

D. Health History for Applicant and ALL Spouse/Domestic Partner/Dependents (Include information for all persons applying for coverage.)

Answer all questions and provide complete details to all "Yes" answers on Page 5, Section F.	Missing information may delay processing this enrollment form.
In the past five (5) years, has any person listed on this enrollment form consulted a health care provider, received treatment (including prescription medications) or been hospitalized for any of the following conditions or diseases?	
D1. Eyes, Ears, Nose and Throat Conditions/Disorders: Eyes/sight: • Glaucoma, cataracts, crossed eyes, detached retina, corneal transplant, infections Ears/Hearing: • Loss of hearing, deafness, infections, eustachian tube dysfunction Nose/breathing: • Deviated septum, polyps, adenoiditis, sinusitis Throat/Swallowing: • Tonsillitis, strep throat, excessive snoring or sleep apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
D2. Skin Conditions/Disorders: Acne, psoriasis, keratosis Birthmarks, dermatitis, eczema, fungal infections, warts, herpes, excessive sweating Moles/pre-cancerous lesions, skin cancer, or melanoma 2nd or 3rd degree burns, scars/keloid, or revisions of cosmetic or reconstructive surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep

continued

Applicant's Social Security Number

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D. Health History for Applicant and ALL Spouse/Domestic Partner/Dependents (Continued)

D3.	Musculoskeletal Conditions/Disorders: Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as: Strain/sprain, fibromyalgia, gout Fracture, internal/external fixations, permanent hardware, amputation/prosthesis Arthritis, joint replacement, herniated disc	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
D4.	Respiratory Conditions/Disorders: Allergies, sinusitis, bronchitis, asthma , pneumonia, collapsed lung, spitting/coughing up blood Shortness of breath, chronic cough, emphysema, COPD, difficulty breathing Tuberculosis, fungal infections	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
D5.	Digestive Conditions/Disorders: Infections of mouth/throat/tonsils Problems with jaw or chewing, ulcers, hernia, gastric reflux, unexplained weight loss or gain, eating disorder, Gastric Bypass/Banding Colitis, Crohn's Disease, Irritable Bowel Syndrome (IBS), chronic diarrhea, intestinal problems, colon polyps, rectal bleeding or hemorrhoids Diseases of the pancreas, liver or gall bladder, hepatitis A/B/C/other, jaundice, Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
D6.	Urinary Conditions/Disorders: Bladder infections, kidney infections, stones, blood in urine Stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
D7.	Heart and Circulatory Conditions/Disorders: Anemia, bleeding/clotting disorders, Hemophilia, thrombocytopenia, Varicose/spider veins, Raynauds, phlebitis, thrombosis, enlarged lymph nodes or lymphadenitis High blood pressure (hypertension), low blood pressure, high cholesterol/lipids Chest pain, angina, heart murmur, palpitations, congestive heart failure, coronary artery disease, rheumatic fever Heart attack, bypass surgery/angioplasty, valve replacement, pacemaker or defibrillator, aneurysm	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
D8.	Metabolic and Endocrine Conditions/Disorders: Diabetes, Insulin Resistance, Metabolic Syndrome, Thyroid disorders Adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis Or other immune disorder (not including the result for the HIV test)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
D9.	Brain/Nervous System Conditions/Disorders: Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, narcolepsy, sleep apnea Confusion, memory loss, Alzheimer's, dementia, head injury, seizures/epilepsy Stroke, paralysis, migraine headaches or chronic severe headaches Tremors, Multiple Sclerosis, Muscular Dystrophy, Reflex Sympathetic Dystrophy (RSD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
D10.	Male Reproductive Conditions/Disorders: Fertility/infertility treatment, low sperm count, sexual dysfunction Erectile dysfunction, enlarged prostate, prostatitis, undescended testes Genital or anal herpes/warts, sexually transmitted diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
D11.	Female Reproductive Conditions/Disorders: a) Pelvic pain, abnormal menstrual bleeding, endometriosis, ovarian cysts, absence of menstruation Abnormal PAP smear, uterine fibroids, fertility/infertility treatment, miscarriage, genital warts/herpes or sexually transmitted diseases Breast cysts/lumps/fibroids, breast implants	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
	b) Has it been more than 40 days since any female listed above had her last menstrual period? If "Yes," provide name(s) and reason: Name(s): _____ Reason(s): _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
	c) Has any female had an abnormal PAP smear? If "Yes," provide details in F1. Date of last normal PAP smear. Name: _____ Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
	d) Is any female applying for coverage pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate? If "Yes," provide name: Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep

continued

Applicant's Social Security Number

Enrollment Form ID Number

D. Health History for Applicant and ALL Spouse/Domestic Partner/Dependents (Continued)

D12. Nervous, Mental and Behavioral: Depression, anxiety, obsessive-compulsive or panic disorders, eating disorders, anorexia/bulimia Attention deficit, chemical imbalance, bi-polar, schizophrenia Substance abuse, counseling or support group, alcohol or chemical dependence	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
D13. Cancer/Tumors: Cysts, tumors or abnormal growths Hodgkin's disease, leukemia or any other cancer or malignancy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
D14. Birth Defects/Congenital Abnormalities: Cerebral Palsy, Birthmarks, developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation Cleft palate/lip, birthmarks club foot, webbed fingers/toes, skull/facial or other physical deformities	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
D15. Other Conditions: Has any person applying for coverage consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s) not listed on this enrollment form?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep

E. Health Related Questions (Include information for all persons enrolling for coverage.)

Answer all questions and provide complete details to all "Yes" answers on Page 5, Section F.		Missing information may delay processing this enrollment form.
E1.	Is any male expecting a child or in the process of adoption or surrogacy with anyone whether or not that person is enrolling for coverage on this enrollment form? If "Yes," provide name below. Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
E2.	Has any person applying been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? If "Yes," provide name(s) below. Name: _____ Name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
E3.	Has any person applying ever used illegal or controlled drugs, or substances such as marijuana, cocaine, methamphetamines, illegal, or controlled IV drugs? Name: _____ Type of Drug/Substance: _____ Date Discontinued: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
E4.	Has any person applying consumed any alcoholic beverage in the last 6 months? (Amount: A drink is 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor.) Name: _____ Type: _____ Amount: _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
E5.	Has any person applying been convicted of a DUI (drunk driving violation)? If "Yes," provide name(s), state(s) and date(s). Name: _____ State: _____ Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
E6.	Has any person applying been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), or ARC (Aids Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
E7.	Has any person applying received any lab results, X-rays, MRI or other diagnostic test results or physical exam results from a physician or medical practitioner that were considered abnormal ?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
E8.	Has any person applying been advised to undergo further medical testing, treatment or surgery which has not yet been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
E9.	Has any person applying been a patient in an outpatient clinic, hospital, surgical center, treatment center or other medical facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep

continued

Applicant's Social Security Number

Enrollment Form ID Number

E. Health Related Questions (Continued)

E10.	Has any person seen any health care provider for any condition, signs, or symptoms which have not yet been diagnosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
E11.	Has any person applying smoked or used tobacco products, such as snuff and/or chewing tobacco, in the last 2 years? If "Yes," provide name(s) below. Name: _____ Date Stopped: _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
E12.	Has any person applying taken prescription medications or been advised to take prescription medications in the last 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
E13.	Has any person applying ever seen, received treatment from, or consulted any health care provider for any other condition or symptom(s) not listed on this enrollment form?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
E14.	Is any person applying a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep
E15.	Is any person applying currently on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> App <input type="checkbox"/> SP/DP <input type="checkbox"/> Dep

F. Detailed Health Information

Check here if more space is needed. Use a separate sheet of paper and staple to the back of this enrollment form.

1. Provide COMPLETE DETAILS to ALL questions answered "Yes" in Sections D and E.

Family Code*	Ques. No.	Dates		Explain Nature of Illness/Condition	Describe Treatment Recommended and/or Received	Do you consider yourself "Fully Recovered"
		From	To			
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

2. List all prescription medications and or doctor's samples taken by you and/or your named spouse/domestic partner/dependents within the last 2 years.

Family Code*	Ques. No.	Date Prescribed (Mo./Day/Yr.)	Date Discontinue (Mo./Day/Yr.)	Name of Medication	Dosage and Frequency	Reason/Condition

*See Family Code explanation on Page 2, Section B.

continued

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F. Detailed Health Information (Continued)

3. For details and medications indicated above, please list ALL doctors, medical attendants, or practitioners you and/or any named spouse/ domestic partner/dependents consulted. If none, please state "None."

Family Code*	Question Number and/or Reason	Name, Address, and Phone Number of Attending Physician

4. List the last doctor visit for all family members, including routine check-ups.

Family Code*	No Visit	Purpose of Visit	Date of Visit	Results of Visit	Name, Address, and Phone Number of Physician
APP					
SP/DP					
01					
02					
03					

*See Family Code explanation on Page 2, Section B.

G. Race/Ethnicity – Optional

Family Code*	(This information is designed for the purpose of data collection and will not be used for determining eligibility, rating, or claim payment.)	01	<input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latin – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____
APP	<input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latin – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____	02	<input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latin – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____
SP/DP	<input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latin – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____	03	<input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latin – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____

H. Effective Date (Requesting an effective date DOES NOT GUARANTEE underwriting to be completed before the date requested.)

If Aetna approves my enrollment form, I am requesting an effective date of the 1st of _____ (month). You will be given the requested effective date if Aetna approves the enrollment form within 30 days. This date must be no later than 90 days after the signature date (Page 10, Section R) of this enrollment form. This date will be honored provided that Aetna's approval is within 30 days of the requested effective date. No requested effective date will be honored prior to or on the signature date.

I. Statement of Enrollment Conditions

Each member of the family will be medically underwritten separately and assigned a separate medical coverage based on his or her own health risk. If one or more family members are not approved, Aetna will cover the approved family members unless otherwise indicated below.

I, the applicant, instruct Aetna not to cover any eligible family members unless all family members are approved for coverage.

I prefer to receive written communication regarding my enrollment form via email.

The information I obtained to assist in applying for this coverage was provided to me: In person Over the phone On the web

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J. PAYMENT OPTIONS - Please select the method of payment for your initial enrollment form and subsequent premium payments.

Initial Payment

- Easy Pay (complete the EFT information below)
 Credit Card (complete the credit card information below)

Recurring or Subsequent Payment

- Easy Pay (complete the EFT information below)
 Bill me monthly

Easy Pay (Electronic Fund Transfer – EFT; An electronic payment of funds from your bank)

Checking Account Number: _____
 Routing Number:
 Name of Bank: _____
 Name(s) on Checking Account: _____



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.** I understand that by electing the EFT box above and with my enrollment form signature on **Page 10, Section R**, 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 upon approval of your enrollment form. Please be advised that such rate adjustment may result in an increase of 0% to 100% of the standard premium.

NOTE: 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 10, Section R**) even if not applying.

Credit Card Payment Option

Credit Card Type <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard	Cardholder's Name (exactly as it appears on the card)
Account Number <input type="checkbox"/> <input type="checkbox"/>	Card Expiration Date

Credit card payment is for your initial premium payment only and will be charged upon approval of your enrollment form. You must elect EFT or monthly billing for your next premium payment.

Any rate adjustment made in accordance with the underwriting process will be automatically charged to your account. Please be advised that such rate adjustment may result in an increase of **0% to 100% of the standard premium.**

K. Statement of Accountability - To be completed if the applicant cannot complete the enrollment form.

I _____ in representation of the applicant, acting as _____
 (describe your relationship) have personally read this form to the applicant and completed the enrollment form because:

Applicant does not have sufficient command of the English language to complete this enrollment form
 Applicant is legally incapacitated and unable to complete this enrollment form

I have read and explained in detail the contents of this enrollment form.

If translated, I also fully explained the "Conditions and Agreement" under **Section Q** to the applicant.

Signature of Representative (**Required**): _____ Today's Date (**Required**): _____
 Print Name: _____
 Street Address: _____
 City, Zip Code, State: _____ Phone Number: _____

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Enrollment Form ID Number									

P. Joinder Agreement

I, _____, have chosen one of the AARP individually underwritten health group products. I understand that such products are underwritten by Aetna Life Insurance Company (the "Insurer") through the AARP Health Insurance Plan (the "Trust"). To receive coverage under the products I have chosen I understand that I will have to join and be a member in good standing of AARP or a spouse/domestic partner of an AARP member and participate in the Trust, as defined in the coverage documents. I also fully understand and agree that no coverage shall become or remain effective as to an applicant (myself, my spouse/domestic partner or dependents) if applicant (myself, spouse/domestic partner or dependents) fails to meet minimum underwriting or eligibility requirements of AARP and/or Aetna. Each applicant who meets the requirements will be offered coverage. I agree to the enrollment criteria as I myself indicated in the Statement of Enrollment Conditions section of this form.

I, the undersigned, also: 1) agree to be bound by the terms of the policy (including all of its attached documentation) issued to the Trust (including any amendments); 2) request coverage for myself and/or for my spouse/domestic partner and/or dependents under the policy or policies issued to the Trust (subject to the applicable underwriting requirements of the Insurer) and that such coverage become effective as of the date of my or my spouse/domestic partner and/or dependents approval for participation under the Trust; 3) agree that the covered benefits provided shall be in accordance and shall be subject to the terms of the policy or policies issued to the Trust; 4) agree to make the required contributions and payment of premiums to the Trust; and 5) also agree that in the case of default, fraud or no payment I will be liable to AARP and the Insurer for such fraud, or unpaid contributions for the coverage period, and AARP and the Insurer may terminate coverage.

Applicant's Signature	Today's Date
Applicant's Spouse (If enrolling for coverage)	Today's Date
Applicant's Dependent (Not a minor)	Today's Date

Q. Conditions and Agreement - Please Read Before Signing Below

IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN. By filing this enrollment form and applying for this coverage, I on behalf of myself and the spouse/domestic partner and/or dependents listed on this enrollment form ("Applicant(s)"), agree to or with the following:

- Aetna may decline this enrollment form. No coverage comes into effect until Aetna approves this enrollment form.
- Coverage and benefits, once they come into effect, are contingent on timely and accurate payment of premiums and any other contribution provided in the plan documents. If payment of premiums or any other contribution is not paid in time and accurately, your coverage will be terminated immediately. If you are terminated for nonpayment of premium, you may no longer be eligible to enroll in any of Aetna's Plans.
- I authorize Aetna to request Applicant(s) medical records, any prescribed medication history and any other medical or pharmaceutical information to process this enrollment form and to make a decision on the approval or disapproval of this enrollment form. I authorize any physician, other healthcare professionals, hospitals, clinics, labs, pharmacies, pharmacy benefit managers or any other healthcare organization ("Providers") that provided treatment or any other service to Applicant(s) that are applying for coverage under this enrollment form to disclose the information required by Aetna and described above to Aetna and/or its designated agents. I understand that I may revoke this authorization at any time while Aetna is determining eligibility for the coverage requested. To do so, I must notify Aetna in writing prior to the issuance of the policy. Revocation of this authorization will result in closure of this enrollment form.
- I understand that Aetna will rely on such information to: 1) underwrite this enrollment form for coverage, make eligibility, risk rating, policy issuance and enrollment determinations for all of the persons applying for coverage; 2) administer claims and determine or fulfill responsibility for coverage and provisions of benefits; 3) administer coverage; and 4) conduct other insurance operations according to federal and state laws and regulations. I authorize Aetna to use such information and to disclose such information to affiliates, Providers, payers, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that Aetna will comply with the HIPAA Privacy Rules and that disclosure of such information will be done in accordance with applicable law.
- I understand that I am entitled to receive a copy of this enrollment form upon request, and that a photocopy is as valid as the original.
- Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice.
- Agents may be compensated based on an individual's enrollment in this plan. Information on insurance agent/broker compensation is available from your agent or at Aetna.com.

Applicant's Social Security Number

Enrollment Form ID Number

R. Signature(s) Required - All persons applying for coverage age 18 and over must sign and date below.

I understand that if my signature/date do not appear and/or are not current and/or my answers are incomplete this enrollment form will be declined.

I have an obligation of communicating to Aetna in writing any medical conditions which occur to Applicant(s) listed in this enrollment form after the signature date on this enrollment form and before the effective date of the coverage, if approved.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form for insurance or statement of claim containing any material 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.

By signing below, Applicant(s) agree to the statements listed above on this enrollment form and represent that all information supplied on this form is true and complete to the best of their knowledge. Applicant(s) have read, understand, and agree to the conditions of enrollment on this enrollment form. Applicant(s) understand that the information supplied in this form will be decisive for the approval of this enrollment form and that any misrepresentation and/or mistake in such information will be reason for cancellation/termination of the coverage for which Applicant(s) are applying.

If adding dependents: I represent that the child/children listed on this form are my legal dependents.

I understand that Aetna requires a copy of my child's birth certificate, adoption decree or legal documentation of responsibility for purposes of dependent verification.

NOTE: Failure to provide such documentation within 60 days of the date of birth or adoption (unless otherwise required by the state) will be grounds for termination/cancellation of the coverage for the newborn or adopted child/children listed above and all claims incurred will become the financial responsibility of the undersigned member.

Applicant's Signature	Today's Date
Applicant's Spouse/Domestic Partner (If enrolling for coverage)	Today's Date
Applicant's Dependent (Not a minor)	Today's Date
Applicant's Dependent (Not a minor)	Today's Date



NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE - AR

[Aetna – AARP Plans
PO Box 14015
Lexington, KY 40512-4015]

According to (your Application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Aetna Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- (3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Applicant's Signature	Date
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SERFF Tracking Number: AENX-G126759996 State: Arkansas
 Filing Company: Aetna Life Insurance Company State Tracking Number: 46676
 Company Tracking Number: AR034610100004
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: 2010 IND- 2010 AARP Paper Application (ALIC)
 Project Name/Number: 2010 IND- 2010 AARP Paper Application (ALIC)/AR034610100004

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	09/07/2010
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Application	Approved-Closed	09/07/2010
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	09/07/2010
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	Outline of Coverage	Approved-Closed	09/07/2010
Bypass Reason:	N/A		
Comments:			
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	09/07/2010
Bypass Reason:	N/A		
Comments:			

SERFF Tracking Number: AENX-G126759996 State: Arkansas
Filing Company: Aetna Life Insurance Company State Tracking Number: 46676
Company Tracking Number: AR034610100004
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: 2010 IND- 2010 AARP Paper Application (ALIC)
Project Name/Number: 2010 IND- 2010 AARP Paper Application (ALIC)/AR034610100004

	Item Status:	Status
Satisfied - Item: AR - Cover Letter - AARP Paper Application	Approved-Closed	Date: 09/07/2010

Comments:

Attachment:

AR_Cover Letter AARP Paper Application.PDF



John W. Ciesielski
Product & Regulatory
Approvals
Law and Regulatory Affairs
151 Farmington Ave., RW61
Hartford, CT. 06156-7330
Phone Number: (845) 279-1282
Fax Number: (860) 952-2065
E-mail: Ciesielskijw@aetna.com

September 1, 2010

Insurance Commissioner Julie Benafield Bowman
Compliance – Life and Health
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: **Aetna Life Insurance Company - NAIC No. 00160054**
Group Accident and Health Insurance
AARP Enrollment Form GR-68388-5 (7-10)

Dear Ms. Benafield:

The form listed above is being submitted, for your Department's review and approval. This AARP Application form will be a paper format application form. The subject form is new and does not replace any form previously approved by your Department.

The enclosed AARP Application form GR-68388-5 (1-10) will be used with our AARP Booklet-Certificate Form GR-9N COMP and GR-9N LME which were approved by your Department on September 27, 2007 under SERFF tracking number AETN-125275941.

This form is intended to modify our AARP Application form to comply with the Patient Protection and Affordable Care Act (PPACA) by updating the dependent age to 26 and by removing the reference to full time student status.

Additionally, we have made the following non-Health Care Reform modifications:

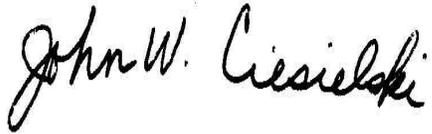
- Plan offerings have been updated;
- Added language to existing 'reason for enrollment' option;
- Updated signature section to remove legal guardian reference from "Applicant/Parent or Legal Guardian Signature" and remove sentence "If person applying is a minor, the application must be signed by a parent or legal guardian."
- Updated signature section to add: "If adding dependents: I represent that the child/children listed on this application are my legal dependents. I understand that Aetna requires a copy of my child's birth certificate, adoption decree or legal documentation of responsibility for purposes of dependent verification."

An Aetna Life Insurance Company electronic fund transfer in the amount of \$50.00 is

enclosed, in payment of your Department's filing fee.

We trust that you will find everything in order, and we look forward to your response. If you have any questions regarding this submission, please do not hesitate to contact me at the above address and telephone number.

Sincerely,

A handwritten signature in black ink that reads "John W. Ciesielski". The signature is written in a cursive, slightly slanted style.

John W. Ciesielski
Consultant