Conditions of Enrollment / Acknowledgements / Attestations / Authorizations

CONDITIONS OF ENROLLMENT Applicant acknowledgments and agreements

On behalf of myself and the dependents listed on this document, I agree to or with the following:

1. I acknowledge that by enrolling, all coverage is underwritten by Aetna Life Insurance Company (Aetna) 151 Farmington Avenue, Hartford, CT 06156.
2. I authorize deductions from my earnings for any premium payments or premium contributions required for coverage or I agree to make any necessary premium payments directly to Aetna as required for coverage, whichever applies.
3. I understand and agree that this document may be transmitted to Aetna or its agent by my employer or its agent (or other plan sponsor entity). I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this document, including those involving mental health, substance abuse and HIV/AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, 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. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand that all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC and Aetna Specialty Pharmacy, LLC, wholly owned subsidiaries of Aetna Inc., are participating providers and independent contractors of Aetna, and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the changes shall be provided in accordance with applicable state law. Aetna does not provide health or dental care services and, therefore, cannot guarantee any results or outcome. Some benefits are subject to limitations or maximums.
6. **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 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:** The falsity of any statement in this document shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by Aetna. **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 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 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 for insurance is guilty of a crime and may be subject to fines and confinement in prison. **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 Ohio 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 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 Rhode Island 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 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 and denial of insurance benefits. **Attention Vermont Residents:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Attention Virginia Residents: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED THE STATE LAW. **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.

YOUR AUTHORIZATION

By enrolling:

1. *I acknowledge that:* The plans are not comprehensive, major medical insurance but are fixed indemnity plans that pay fixed daily dollar benefits for covered services without regard to the health care provider's actual charges. The benefit payments are not intended to cover the full cost of medical care. I am responsible for the provider's charges.

   THESE PLANS DO NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THESE ARE SUPPLEMENT TO HEALTH INSURANCE AND ARE NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.

2. *I represent that all information supplied in this document is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment.*

3. *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 is effective date with no benefits payable. I understand conditions disclosed on this form may be subject to all conditions of my employer's (*or other sponsoring entity's*) plan. My signature indicates that I have reviewed all information and statements on this form for completeness and accuracy. I acknowledge that I have read the Privacy Notice and Misrepresentation Section during the enrollment process and know that I have a right to receive a copy of this authorization upon request. I agree that a copy of this authorization is as valid as the original.*

4. I hereby attest that I am Actively at Work (working or available to work and meet the criteria set by my employer (or other sponsoring entity) to be eligible to enroll).

5. *If I am a resident of Maine or New Hampshire, I attest that I've received the following link to the Specified Disease Buyer's Guide, which is also included with my enrollment materials:*
   http://coe.avpenroll.com/media/1594/maine-nh-prod_serv_consumer_guide_cancer.pdf

6. *If I am a resident of Utah, I attest I've received the following links to the Specified Disease Buyer's Guide, which is also included with my enrollment materials:*
   http://coe.avpenroll.com/media/1590/aetna-utah_ci_buyersguide.pdf *&*
   http://coe.avpenroll.com/media/1589/sp_aetna-utah_ci_buyersguide.pdf

7. *If I am a resident of New Mexico, I attest that I understand this/these Supplemental Health plans do not provide comprehensive health benefits and that I have read and understood the attached COVID-19 Notice to New Mexico residents available through the following link:*
   http://coe.avpenroll.com/media/1623/covid-19-notice-for-nm-residents.pdf