

Agent/Agency Application for Medicare Registration

Agent/Agency Information (please print):

List the state(s) in which you are requesting registration. Please attach copies of licenses.	Are you a resident of this state? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please check appropriate item: <input type="checkbox"/> Partnership <input type="checkbox"/> Individual/Sole Proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Other (please identify)
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Full Name of Agent or Agency. Please note that name and Tax ID must correspond.	Federal Employer Identification Number (Tax ID Number) OR Social Security Number that corresponds to legal name as provided
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Business Mailing Address (Include Post Office Box if applicable):

City	State	Zip Code
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Length of time at this location (If less than 5 years, please include on a separate sheet of paper a list of all locations):

Date of Birth	Phone Number	Fax Number	E-mail Address
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Resident Mailing Address (If Applicable)	Resident City
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Resident State	Resident Zip Code	Resident Phone Number	Resident Fax Number
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NOTE: A minimum of \$1,000,000 specific and \$1,000,000 aggregate E&O coverage is required for all Producer Registrations.

E&O coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount of E&O coverage:	E&O carrier & policy #:	Copy of E&O declaration page or Certificate of Insurance included with application <input type="checkbox"/> Yes
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The following questions are applicable to the agent/agency/corporation/ partnership and to each of the partners, members, directors, officers or agents individually. If the answer is "Yes" to any of these questions, provide complete details on a separate sheet of paper. To the best of your knowledge:

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| <p>A. Have you or any of the partners, directors, officers or agents within this corporation/partnership ever been fined, reprimanded, sanctioned or been the subject of a consent decree in any state for a violation of insurance laws, HMO regulations or other administrative regulations?
<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Have you or any of the partners, members, directors, officers or agents within this corporation/partnership ever been refused license to sell Insurance/ HMO, or has a license to sell Insurance/ HMO ever been suspended or revoked by any state?
<input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>C. Have you or any of the partners, members, directors, officers or agents within this corporation/partnership ever been convicted of a crime, whether felony or misdemeanor, other than a minor traffic violation?
<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>D. Have you or any of the partners, members, directors, officers or agents within this corporation/partnership ever been employed by an Insurance/HMO company, or another organization providing for or assisting with administration of health care or other employee benefits, where the employment contract was terminated or non-renewed because of allegations of wrongdoing?
<input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>E. Have you or any of the partners, members, directors, officers or agents within this corporation/partnership ever surrendered any insurance or HMO license, whether voluntary or involuntary?
<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>F. Are you or any of the partners, members, directors, officers or agents within this corporation/partnership currently a named party in any lawsuit?
<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>G. Have you or your company ever declared bankruptcy, had a lien placed against you or your company, been a judgment debtor or had other problems with your or your company's credit history?
<input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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If you answered Yes to any of the questions (A to G), please give details and the current status. (Attach any pertinent documentation.)

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I hereby certify that I have read and understand the items on this form and that my answers are true and complete to the best of my knowledge. I have been advised that one or more Aetna companies (the Company) or any of its affiliated companies, agents or subcontractors, may conduct investigations in connection with my request to represent the Company in the solicitation of Aetna products as described in the Producer Agreement. I hereby consent to the Company requesting and obtaining all information as discussed in this paragraph and for all such reports to be requested by and provided to the Company.

I understand that a routine inquiry may be made as a requirement for Medicare registration. If applicable, the Company may obtain reports from a consumer reporting agency, an investigation report or inquiries from a State Insurance Department. Any information that the Company obtains about me will be treated as confidential.

FAIR CREDIT REPORTING ACT — As part of its regular procedures, the Company may obtain an investigative consumer report. It may deal with character, reputation, personal traits and lifestyle. It may involve personal interviews with friends, neighbors and associates.

I understand I have the right to make, within a reasonable amount of time, a written request for details on the name and address of the agency making the report. I further understand that, depending on the state law, subjects of an investigative consumer report may have the right to: 1) request that they be interviewed in connection with the making of the report; and 2) receive a copy of the report, upon request. My signature below constitutes my agreement and authorization to the above.

In signing this application I certify that I have not been convicted of any criminal felony involving dishonesty or breach of trust or been convicted of an offense under section 1033 of the Violent Crime and Law Enforcement Act of 1994. I further agree to immediately inform Aetna Inc. of any conviction of the types described in the preceding sentence.

I agree to abide by the Disclosure Requirements mandated by the states in which I operate. I understand and agree to follow the guidelines of Aetna's HIPAA Privacy and GLBA Security Guidelines which are contained in the Aetna Producer Agreement.

I understand that if any of the information I provided is found to be incorrect or incomplete, it may be grounds for non-registration or my immediate termination at the discretion of the Company.

My signature below signifies my agreement to Aetna's current producer agreement, which is located at http://www.aetna.com/producer/data/SGAA_Kit/Prod_Agreement.pdf; acceptance of the terms and conditions set forth in the Aetna Medicare Marketing Standards of Conduct of which I have received a copy and understood; and acknowledgement that I have received and reviewed the training information associated with the Medicare Advantage Plans or the Medicare Prescription Drug (Part D) Plans offered by Aetna, as applicable.

***If requesting firm registration in the following states, please provide a completed application along with all applicable licenses for a related individual producer: AL, AR, CT, DC, DE, FL, GA, IA, KS, KY, MD, ME, MI, MN, MS, NC, ND, NE, NH, OH, OK, PA, RI, SC, SD, TN, VA, VT, WI, WV**

Applicant's Signature
(Agent or Agency Officer if applying for Agency Registration)

Print Name Title Date

Licensing Contact Name Licensing Contact Phone Number

