Aetna Advantage Plans for Individuals, Families and the Self-Employed

Attestation for Newborn or Adopted Child/Children

Subscribers Social Security Number

Send completed form to:

Attention: Individual Eligibility Support
Aetna Advantage Plans
PO Box 730
Blue Bell, PA 19422
FAX Number: 860-975-3119

A. Subscribers Information

Name of Policy Holder	**AETNA Policy ID Number**
Mailing Address (All Aetna correspondence will be sent to this address) - Include Apartment Number, if applicable. Number, Street _____ City, State, ZIP Code _____	**Billing Address** (If you prefer your bill to be mailed to a different address than listed above.) - Include Apartment Number, if applicable. Number, Street _____ City, State, ZIP Code _____
Telephone Numbers **Home:** ( ) **Work:** ( ) **Cell:** ( )	
Email Address	

B. Newborn or Adopted Child/Children Information

Dep Code	Name Last	First	M.I.	Social Security Number (if available)	Date of Birth (MM / DD / YYYY)	Age	Sex (M/F)	Primary Office ID# (HMO Product Only) (if available)
01								
02								
03								
04								

C. Enrollment of Newborn or Adopted Child/Children as Dependent/Dependents on to Existing Policy

☐ **Check here if you want to enroll your newborn or adopted child/children (listed above) as dependent/dependents on to your existing Aetna Advantage Plan policy.** ***You will be billed the additional premium for your child/children with your monthly billing statement.***

D. Signature(s) Required

I represent that the child/children listed above 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.

I understand that falsifying information for the purpose of obtaining health insurance for my newborn or adopted child/children with intent to defraud any insurance company, including concealing information for the purpose of misleading any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I understand that Aetna will pursue cases of suspected insurance fraud and may report all activities related to such investigations to state regulators and law enforcement agencies.

By signing below, I agree to the statements listed above and attest that all information supplied on this form is true, complete and correctly recorded by me and that any misrepresentation and/or mistake in such information will be reason for cancellation/termination of the coverage for my dependent(s) for which I am applying.

Subscribers Signature	**Today's Date**