

Producer Guide

Aetna Senior Supplemental Insurance



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Introduction

Section 1

aetna[®]

1. Introduction

Table of contents

The Aetna brand, mission & values

Our Senior Supplemental products and underwriting companies

Key terms

Table of contents

Use the quick links on this page to jump to specific sections.

Helpful hint: If you'd like to search for a specific term, just press Ctrl+F.

1. Introduction

Table of contents

The Aetna brand, mission & values

Our Senior Supplemental products and underwriting companies

Key terms

2. Agent Experience

Making it easy to do business

Agent communications

Agent secure website

Online tools and reporting

Agent services team

Sales management team

3. Contracting, Licensing and Appointment

Contract types

Initial contracting

The contracting process

Just In Time appointment

Pre-appointment states

Background check

Contract and demographic changes

Contracting quick reference guide

Checking appointment status

Agent termination information

4. Compensation

Compensation overview

How we pay

Commission

Initial sales

Renewal sales

Advance commissions

Chargebacks

Unearned commission

1099 forms

How termination affects compensation

Assignment of commissions

5. Marketing Materials

How to order sales supplies

Using our logo

6. Submitting Business

Before completing an application

Power of attorney

Medicare Supplement applications

Guaranteed issue and

12 month trial rights

Open Enrollment

Underwritten applications

Anniversary and birthday rules

Completing the application

Choosing an effective date

Signature date

Application fees

Initial draft date

Know your bill date

Payment methods

Net billing

Telephone interview

Final Expense Jet pre-approval interview

Final Expense Jet point of sale

Underwriting

Reasons we'll close an application

Declined applications

You can always access the latest version of this guide on aetnaseniorproducts.com.

Content subject to change to ensure compliance with Aetna Senior Supplemental Insurance requirements.

To the extent there is any conflict between the descriptions in this guide and the terms of your contract with Aetna Senior Supplemental Insurance, the terms of the contract control.

Continued →

Table of contents »

1. Introduction

[Table of contents](#)

The Aetna brand, mission
& values
Our Senior Supplemental
products and
underwriting companies
Key terms

[Table of contents »](#)

Table of contents (continued)

Use the quick links on this page to jump to specific sections.
Helpful hint: If you'd like to search for a specific term, just press Ctrl+F.

7. Policyholder Experience

- Policyholder services
 - Sending us documentation
- Free look period
- Withdrawing or canceling an application
- Changing policy benefit amounts
- Changing Final Expense benefit amounts
- Changing an effective date
- Changing a bill date
- Reinstatement
 - Medicare Supplement
 - Final Expense
 - Complimentary
- Canceling a policy
- Refunds
- Explanation of benefits (EOB)
- Claims
 - Medicare Supplement
 - Final Expense
 - Complimentary
- Online tools for members
 - Member secure website
 - Correspondence preferences
 - ID cards

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1. Introduction

Table of contents

[The Aetna brand, mission
& values](#)

Our Senior Supplemental
products and
underwriting companies

Key terms

Table of contents »

The Aetna brand, mission & values

Who we are

Aetna is one of the nation's leading diversified health care benefits companies. We serve an estimated 46 million people with information and resources to help them make better health care decisions. Our mission, values and goals are expressed through The Aetna Way and encompass our shared sense of purpose as we pursue our operational and strategic goals.

Why we exist: The Aetna mission and values

We're committed to helping people achieve health and financial security. We do this by providing easy access to safe, cost-effective, high-quality health care and protecting their finances against health-related risks. Building on our 163-year heritage, Aetna is a leader in working with doctors, hospitals, employers, patients, public officials and others to build a stronger, more effective health care system.



1. Introduction

Table of contents

The Aetna brand, mission
& values

[Our Senior Supplemental
products and
underwriting companies](#)

Key terms

Our Senior Supplemental products and underwriting companies

Aetna Senior Supplemental Insurance is:

Entities:

- Aetna Health and Life Insurance Company (AHLIC)
- Aetna Health Insurance Company (AHIC)
- Aetna Life Insurance Company (ALIC)
- American Continental Insurance Company (ACI)
- Continental Life Insurance Company of Brentwood, Tennessee (CLI)

Products:

- Medicare Supplement insurance
- Final Expense whole life insurance
- Protection SeriesSM:
 - Dental, Vision and Hearing insurance
 - Cancer and Heart Attack or Stroke insurance
 - Hospital Indemnity insurance
 - Hospital Indemnity Flex insurance
 - Recovery Care short term insurance
 - Home Care Plus indemnity insurance

NOTE: All products and entities are not available in all states.

You can quickly check
our current product
availability by state.

Simply scan this QR
code with your mobile
device. Or, [click here](#).



Table of contents »

1. Introduction

Table of contents

The Aetna brand, mission
& values

Our Senior Supplemental
products and
underwriting companies

[Key terms](#)

Key terms

Take a minute to review key terms and acronyms below, which are used in this guide or other communications in addition to other key terms in your Aetna Senior Supplemental Insurance agreement.

AEP	Annual Election Period
Aetna	Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Companies and its affiliates (Aetna).
Aetna Senior Supplemental Insurance	Aetna Senior Supplemental Insurance is the collective name used for products and services provided by Aetna Health Insurance Company, Aetna Health and Life Insurance Company, Aetna Life Insurance Company, American Continental Insurance Company, and Continental Live Insurance Company of Brentwood, Tennessee (Aetna companies)..
aetnaseniorproducts.com	Your website for Aetna Senior Supplemental Insurance information: www.aetnaseniorproducts.com
CMS	The Centers for Medicare & Medicaid Services, a federal agency within the U.S. Department of Health and Human Services (DHHS) that administers the Medicare program.
Downline agent	A person or entity whose contract connects to one or more uplines; or a licensed-only agent.
Licensed-only agent or LOA	Any licensed insurance agent who is either employed by or under exclusive contract with an upline to sell or refer insurance products for the upline.
MA/MAPD	Medicare Advantage/Medicare Advantage and Prescription Drug
PDP	Medicare Part D, a stand-alone prescription drug plan.
Telephone Consumer Protection Act (TCPA)	A federal consumer privacy statute enacted in 1991. It regulates and restricts the use of automated technology to call mobile phones. The statute applies to outbound telephone calls, including voice messages, prerecorded or artificial voices, SMS text messages and faxes (i.e., telemarketing).
Termination without cause	This Agreement may be terminated for any reason or no reason, at any time, by either party, upon written notice to the other party, which notice shall be provided no later than 15 days prior to the termination date.
Upline	A firm, agency, organization or person with downline agents.
We (and other first-person pronouns)	Your team at Aetna Senior Supplemental Insurance. We'll also use other pronouns here, like "our" and "us."
You (and other second-person pronouns)	You, the reader. We'll note if a topic is specific to upline partners, writing agents or downline agents only. Sometimes we'll use other pronouns, like "your."

[Table of contents »](#)

Agent Experience

Section 2

aetna[®]

2. Agent Experience

Making it easy to do business

- Agent communications
- Agent secure website
- Online tools and reporting

Agent services team

Sales management team

Making it easy to do business with Aetna Senior Supplemental Insurance

Agent communications

It's quick and easy to stay in the know. Just make sure you have a current email address on file with us and we'll keep you updated about:

- Products
- Training opportunities
- Operations, and more

We send communications to the email you gave us when you first contracted. To start receiving our communications at a new email address, or if you're not getting our communications, you can update your email address on aetnaseniorproducts.com (agent side) or by contacting the Agent Services team.

And, you can always access an archive of past communications on aetnaseniorproducts.com (agent side).

[Table of contents »](#)

2. Agent Experience

Making it easy to do business

- Agent communications
- [Agent secure website](#)
- Online tools and reporting

Agent services team

Sales management team



aetnaseniorproducts.com

[Table of contents »](#)

Making it easy to do business with Aetna Senior Supplemental Insurance

Agent secure website

Our website is located at www.aetnaseniorproducts.com. From this homepage you can review general information about our products and services.

The secure agent side of our website is designed to help you manage your business with us. It includes reports specific to your sales, communications, product training, top producers, sales materials, and news specifically for our senior supplemental insurance business. Our electronic applications and rate quote tools are also available from the agent secure website.

Agent secure log-in

Under the Secure Login section you can click on “Agents” and sign in with the User Name and Password you created.

If this is the first time you’ve used our website, click on the “Register Now” button after you click “Agents” to register your account.

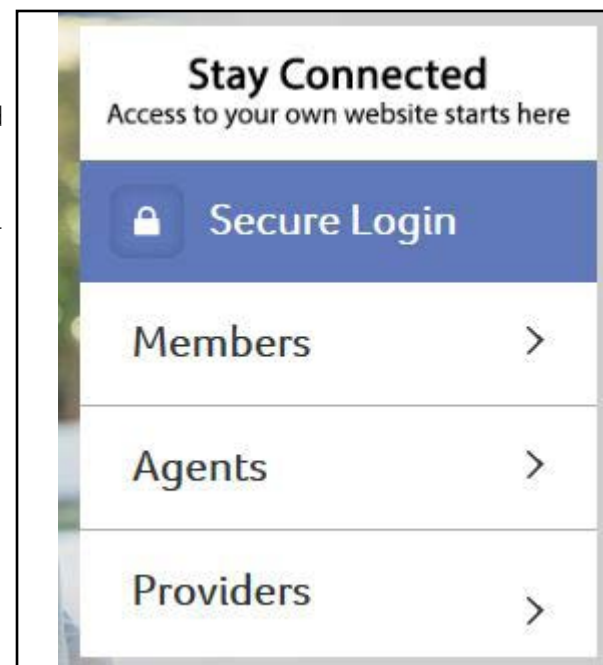
If you need assistance logging in to the agent secure site, please contact the Agent Services team at **1-800-264-4000**.

- Note: If you ever need to change your password, click “your profile” in the upper right hand corner after you’ve logged in.

Agency secure log-in

If you’re an individual agent who owns an Agency, you’ll need to register on the website twice.

Register once for you, and once for your agency.



2. Agent Experience

Making it easy to do business

- Agent communications
- Agent secure website
- Online tools and reporting

Agent services team

Sales management team

Making it easy to do business with Aetna Senior Supplemental Insurance

Agent/broker tools	Aetna-specific tools
Home Office Directory	www.aetnaseniorproducts.com/assets/pdf/Directory_For_Agents.pdf
Product Information	www.aetnaseniorproducts.com/ssi/secure/agentSecure/productsTools/productAvailability.html
Rate Quote	www.aetnaseniorproducts.com/ssi/secure/agentSecure/productsTools/rateCalculator.html
E-App	www.aetnaseniorproducts.com/ssi/secure/agentSecure/myCompassTools.html?pageInd=tools
E-App Training	www.aetnaseniorproducts.com/ssi/secure/agentSecure/training/eAppTraining.html
My Profile	www.aetnaseniorproducts.com/ssi/secure/agentSecure/myBusiness/aboutYou/myProfile.html
My Business	www.aetnaseniorproducts.com/ssi/secure/agentSecure/myBusiness/myBusiness.html
Webinars	www.aetnaseniorproducts.com/ssi/secure/agentSecure/training/webinarReservation.html
Sales Guides	www.aetnaseniorproducts.com/ssi/secure/agentSecure/training/salesGuides.html
Communications	www.aetnaseniorproducts.com/ssi/secure/agentSecure/myCompassCommunication.html?pageInd=communications
Email Alerts	www.aetnaseniorproducts.com/ssi/secure/agentSecure/myBusiness/aboutYou/myProfile.html
Guide to Ethical Market Conduct	www.aetnaseniorproducts.com/assets/pdf/ToolsAndTraining/Documents/GF17243-1106_092209_gnw.pdf
Multipurpose Confidentiality Addendum and Producer Conduct Rule	www.aetnaseniorproducts.com/assets/pdf/ToolsAndTraining/Documents/MultipurposeConfidentialityAddendum_010115.pdf

[Table of contents »](#)

2. Agent Experience

Making it easy to do business

- Agent communications
- Agent secure website
- Online tools and reporting

Agent services team

Sales management team

The Agent Services team

The Agent Services team is focused on your needs as a new or experienced agent/agency. We want to help you grow your business.

The Agent Services team can help answer your questions about:

- Product details and benefits
- Placing sales supply orders
- Field Communications
- Navigation and login support for aetnaseniorproducts.com
- Submitting a new application (E-app or paper)

Additional assistance available:

- New application rate quotes
- Drug/formulary lookup
- Checking active appointment status for products and states
- Providing contact information for other departments
- Updating agent email and mailing addresses

The Agent Services team

Phone: **1-800-264-4000**

Email: AetSSIInformation@aetna.com

Hours: Monday through Friday, 7:30 a.m. - 4:30 p.m. CT

Fax number: **1-855-690-0893**

[Table of contents »](#)

2. Agent Experience

Making it easy to do business

- Agent communications
- Agent secure website
- Online tools and reporting

Agent services team

[Sales management team](#)

The sales management team

We want to provide you with the best possible service. To help with that, we've divided the United States into three strategic marketing regions. Each region includes a dedicated Regional Vice President, Regional Sales Manager and Regional Sales Specialist. Focused on the states in their region, our sales management team is standing by to help you make the most out of the products and services we offer. Whether it's over the phone, on the road, or in your office, we're here to help you.

Regional vice presidents:

- Conduct MGA on-site training for any Aetna Senior Supplemental Insurance product
- Analyze MGA production
- Provide assistance in resolving issues or concerns
- Lead webinars on any Aetna Senior Supplemental Insurance product

Regional sales managers:

- Conduct mid-level agency on-site training for any Aetna Senior Supplemental Insurance product
- Provide assistance in resolving issues or concerns
- Lead webinars on any Aetna Senior Supplemental Insurance product

Regional sales specialists:

- Resolve escalations regarding:
 - contracting
 - agent appointments
 - new business
 - commissions
- Lead webinars on any Aetna Senior Supplemental Insurance product



For sales management team contact information, please see our [Home Office directory](#).

[Table of contents »](#)

Contracting, Licensing and Appointment

Section 3

aetna[®]

3. Contracting, Licensing and Appointment

Contract types

Initial contracting

The contracting process

- Just In Time appointment
- Pre-appointment states
- Background check

Contract and demographic changes

Contracting quick reference guide

Checking appointment status

Agent termination information

Contracting, licensing and appointment

License- The agent retrieves a license through the state Department of Insurance. The agent must receive their license from the state before they request to contract with Aetna Senior Supplemental Insurance.

Contract- An agreement between the agent and Aetna Senior Supplemental Insurance that must be signed. Once executed, the contract is a legally binding document.

Appointment- An agreement between Aetna Senior Supplemental Insurance and the state Department of Insurance. This agreement is Aetna Senior Supplemental Insurance letting the state Department of Insurance know we've given the agent the right to sell our products in that state.

Contract types

- **Agent contract:** A Licensed Only Agent (LOA) is an agent who is assigned to and supervised by a Marketing General Agent (upline). We don't pay direct commissions to LOA agents. Their compensation is part of the agreement with their upline.
- **General Agent contract:** A General Agent (GA) is an agent who is assigned to and supervised by a Marketing General Agent (upline). We pay direct commissions to GA agents.
- **Marketing General Agent contract:** A Marketing General Agent (MGA) is a GA who manages multiple agencies, GA and LOA agents.

Initial contracting for new agents

New agents can begin the contracting process using either the online tool or by sending us the required paperwork by fax at **1-866-618-4993**. You'll find the required paperwork listed on the contracting [Quick Reference Guide](#).

When we onboard you as a new agent, we'll appoint you for all available products in the states where you are actively licensed to sell Medicare Supplement and Health products. This way, you don't need to keep requesting additional products and states. You're already good to go.

When we launch new products or change entities, we'll go ahead and auto-appoint you if you're licensed and have submitted business in the past 12 months.

[Table of contents »](#)

3. Contracting, Licensing and Appointment

Contract types

Initial contracting

[The contracting process](#)

- [Just In Time appointment](#)
- [Pre-appointment states](#)
- Background check

Contract and demographic changes

Contracting quick reference guide

Checking appointment status

Agent termination information

[Table of contents »](#)

The contracting process

Just In Time appointment

For all states except Pre-appointment states, we process “Just In Time” (JIT) appointments. This means we submit the appointment agreement to a state Department of Insurance (DOI) once you’ve submitted your first application in that state.

Pre-appointment states

If an application is submitted in a pre-appointment state with an agent signature date that’s earlier than the state appointment date, the application will not be accepted.

You must be appointed before writing any applications for the following Pre-appointment states:

- Alabama
- Kentucky
- Louisiana
- Montana
- Ohio
- Pennsylvania
- Utah
- Vermont
- Washington
- Wisconsin

3. Contracting, Licensing and Appointment

Contract types

Initial contracting

The contracting process

- Just In Time appointment
- Pre-appointment states
- [Background check](#)

Contract and demographic changes

Contracting quick reference guide

Checking appointment status

Agent termination information

The contracting process (continued)

Agent background check and review process

As part of the contracting process, we perform standard background investigations/regulatory reviews that include but are not limited to:

- National Criminal Search
- Federal Criminal Search
- County Criminal Search
- Credit Report- (LOA agents excluded)
- Professional License Verification
- Medicare Debarred & Exclusion Lists (OIG, SAM and OFAC)

If the background investigation/regulatory review returns as approved, we'll complete the final steps of the contracting process. If a background investigation/regulatory review does not return as approved, it will be reviewed by our contract review team to decide whether the agent can move forward with the contracting process or if the contract will be declined.

When an applicant is under review, we'll send a Pre-Adverse action letter and a copy of the applicant's background/credit report to the applicant's email address. If no email address is available, the letter and report will be mailed to the applicant. During the review process, the applicant has 10 business days from the date of the letter to provide a response.

If the applicant wishes to dispute the accuracy of the information in the background/credit report, the applicant should contact Applicant Insight, the consumer reporting agency that provided the report, at **1-800-771-7703 x 2048**.

The applicant may submit any additional documentation for review with background and/or credit findings by email to Medicarebackground@aetna.com.

We complete the final steps

If the applicant is approved, we'll send a welcome letter to the agent/agency and their upline.

If the applicant is not approved, we'll send a decline letter to the agent/agency and their upline.

If your application is not approved, you can re-apply any time that you feel your background or credit status has changed and would like us to start a new application and review process.

[Table of contents »](#)

Continued
→

3. Contracting, Licensing and Appointment

Contract types

Initial contracting

The contracting process

- Just In Time appointment
- Pre-appointment states
- Background check

[Contract and demographic changes](#)

[Contracting quick reference guide](#)

[Checking appointment status](#)

Agent termination information

[Table of contents »](#)

Contract and demographic changes

Demographic changes

If you want to change the name on your agent record, we'll need a copy of your license showing your new name.

If your agency name is changing, you'll need to send us a detailed request and a copy of your agency license showing the new agency name.

If your agency Tax ID is changing, it is considered a hierarchy change and we'll have to issue your agency a new writing number.

Contracting Quick Reference Guide (QRG)

We've put together a reference guide to help you know what kind of documentation we need for certain contracting topics. Here's a list of what you'll find on the [QRG](#):

- New agent
- Adding a legal entity
- Adding additional state appointments
- Adding commission advancing
- Changing your commission level
- Setting up Electronic Funds Transfer (EFT)
- Hierarchy changes
- New product launches

Checking on updated appointment status

An agent or their upline may use our website www.aetnaseniorproducts.com to see updates made to an agent's onboarding status and appointments, which will appear 24 hours after being completed.

3. Contracting, Licensing and Appointment

Contract types

Initial contracting

The contracting process

- Just In Time appointment
- Pre-appointment states
- Background check

Contract and demographic changes

Contracting quick reference guide

Checking appointment status

[Agent termination information](#)

Agent terminations

All agent/agency appointment terminations are reviewed by our business leadership. In order to comply with state timing requirements, appointment terminations are processed in our system on the same day we send the termination letter to the agent. Typically, the effective date of the termination is 15 days after the notice is sent. The effective date may vary depending on the reason for the termination.

[Table of contents »](#)

Compensation

Section 4

aetna[®]

4. Compensation

Compensation overview

- [How we pay](#)
- [Commission](#)

Initial sales

Renewal sales

Advance commissions

Chargebacks

Unearned commission

1099 forms

How termination affects
compensation

Assignment of commissions

Compensation overview

“Compensation” means first year, renewal and override commissions and other forms of remuneration earned by an agent in connection with the sale of our Senior Supplemental insurance products.

In addition to the following overview, be sure to refer to your contract. To the extent there is any conflict between the description below and the terms of your contract with Aetna Senior Supplemental Insurance, the terms of the contract apply.

How we pay

The compensation year is January 1 through December 31.

We strongly recommend signing up for EFT. You'll get paid faster, more frequently (2 days/week), and for any dollar amount. We run commission cycles on Wednesday and Saturday. Due to your individual bank's internal procedures, it may take up to 48 hours before you receive your commission payment.

If you don't sign up for EFT, we will mail you a check for your commissions. Checks are printed on Tuesday and are only mailed once per week. Keep in mind that our system will wait until your commission total is over \$25 before producing a check.

We send your payment using the address or EFT information we have on record.

If you need to change the address or EFT information for an agent/agency, send your changes to AetSSICommissions@Aetna.com.

- You'll have to submit the [Agent EFT authorization form](#) for any EFT updates.
- If your agency has any LOAs, we will update the address for those records as well.

Based on your contract, you have 30 days to contest payment and calculations on a commission statement.

Commission

Marketing General Agents and General Agents are paid a commission for each member they enroll in an Aetna Senior Supplemental product in accordance with their contract.

Commissions for licensed-only agent (LOA) sales pay directly to their upline.

We calculate commissions on the commission cycle after the premium is applied to the policy. When a policyholder pays modal premium, our system calculates commission payment based on your commission schedule and will disburse on the next available commission cycle.

[Table of contents »](#)

4. Compensation

Compensation overview

- How we pay
- Commission

[Initial sales](#)

[Renewal sales](#)

Advance commissions

Chargebacks

Unearned commission

1099 forms

How termination affects
compensation

Assignment of commissions

Initial and renewal sales

Initial sales

- “Initial sale” means an applicant is enrolling in a product for the first time.

We pay Initial Sale commissions in accordance with the year 1 commission rate on the corresponding schedule.

Renewal sales

- “Renewal sale” means any premium paid after the first payment. (This could be monthly, quarterly, semi-annually or annually.)

We pay renewal sale commissions based on the age of the policy years 2 and beyond.

[Table of contents »](#)

4. Compensation

Compensation overview

- How we pay
- Commission

Initial sales

Renewal sales

[Advance commissions](#)

[Chargebacks](#)

[Unearned commission](#)

1099 forms

How termination affects
compensation

Assignment of commissions

Advance commission, chargebacks and unearned commission

Advance commissions

- You must be set up for [advance commissions](#) prior to the signature date on the application.
- If your EFT transaction is rejected twice, the commissions advance will charge back to your agent commissions account and change from advance to paid as earned.
- If your policyholder is paying their premium by direct bill, that policy is not eligible for advance commissions.

Chargebacks

If a policy is cancelled, withdrawn or not taken within the first 30 days of policy receipt, 100% of the premium will be refunded to the applicant and 100% of commissions will charge back to the agent.

If a policy is cancelled after 30 days, the premium and commissions will be prorated.

If a policy is rescinded for material misrepresentation within the two year contestability period, commissions will charge back to the agent.

Unearned commission

If you're advanced commission for a policy and the policy is cancelled, the advance will be considered unearned commission. Unearned commission will charge back to your agent commission account. If a chargeback causes your agent commission account balance to be negative, you won't receive commission payments until commissions from new submitted business bring your agent commission account positive again.

[Table of contents »](#)

4. Compensation

Compensation overview

- How we pay
- Commission

Initial sales

Renewal sales

Advance commissions

Chargebacks

Unearned commission

[1099 forms](#)

How termination affects
compensation

Assignment of commissions

1099 forms

1099 forms

Commissions are reported via the Internal Revenue Service (IRS) 1099 process. 1099 MISC forms are postmarked to all eligible recipients by January 31 of a given year and mailed to the payee address on file.

A 1099 MISC form will only generate to an agent if annual earnings are \$600 or above.

If earnings are less than \$600, agents can obtain earning totals by visiting our secure agent website and viewing their commission reports. Note: The last statement date in December pays in January, so those earnings count toward the following tax year. (Example: A 12/22/16 statement date will count toward 2017 taxes, as payment is not generated and sent until after 1/1/17.)

- We mail 1099s on January 31 for the prior tax year.
- If you need another copy of your 1099, we can fax or mail you a duplicate.
- We can't send your 1099 to your email address.
- If you need to change information on your 1099, please call the [Commissions department](#).

[Table of contents »](#)

4. Compensation

Compensation overview

- How we pay
- Commission

Initial sales

Renewal sales

Advance commissions

Chargebacks

Unearned commission

1099 forms

[How termination affects compensation](#)

Assignment of commissions

How termination affects compensation

How termination affects compensation

If you are terminated, but are still in good standing, you will continue to receive renewal commissions according to your commission schedule.

If you are terminated for cause, we reserve the right to terminate your commission payments.

Recovery process for terminated agents with debit balances

If you are terminated and have a debit balance on your agent commission account, we will pursue collection of debt.

[Table of contents »](#)

4. Compensation

Compensation overview

- How we pay
- Commission

Initial sales

Renewal sales

Advance commissions

Chargebacks

Unearned commission

1099 forms

How termination affects
compensation

[Assignment of commissions](#)

[Table of contents »](#)

Assignment of commissions

Assignment of commissions

An assignment of commissions (AOC) is an agreement between two parties to revert commissions to another agent or agency.

You can revert commissions to your agency (GA to GA) or to your personal SSN (LOA to GA).

You can sell your block of business to another agent or agency.

- Your status and state appointments will be terminated.
- If you request to be re-contracted, you must submit new contract paperwork.

Any and all debit or advance balances either must be paid in full or a payment arrangement approved by the Debit Consultant must be agreed to before we complete the Assignment of Commissions.

The Assignee will assume the tax liability for the reverted commissions. The commissions will be reported to the IRS under the Assignee Tax ID# from the date the assignment was completed. These commissions are considered renewals only.

Items needed:

- [Assignment of Compensation form](#) - Pages 1 & 2
- [W9 form](#) - required for new Agencies
- Explanation of why requesting Assignment of Commission
- Bill of Sale - if applicable
- Legal documents - if applicable
- [EFT Authorization form](#) - for direct deposit

Assignment of commissions for a deceased agent

A deceased agent's commissions will be payable to his/her surviving spouse per agent contract. If the agent does not have a surviving spouse, we will honor legal documents such as a will, trust, or court ordered paperwork that indicate the commissions will be payable to other family members or his/her estate.

Items needed:

- Death Certificate of deceased agent
- [W9 form](#) - for surviving spouse
- Other legal documents as noted above

Marketing Materials

Section 5

aetna[®]

5. Marketing Materials

How to order sales supplies

Using our logo

How to order your sales supplies

It's easy for you to order the supplies you need to sell our products

Once you've logged in to the agent side of aetnaseniorproducts.com, go to Tools, then **Order Supplies/Download Forms**.

Make sure that you're ordering materials based on your applican'ts state of residence since sales materials and availability vary by state.

Also, if you order a kit instead of individual items, you can be sure that you have all the required documents to submit your application.

Our order fulfillment is completed by Donnelley Financial Solutions in Charlotte, North Carolina.

For step by step ordering instructions, please review this [user guide](#).

[Table of contents »](#)

5. Marketing Materials

How to order sales supplies

[Using our logo](#)

Using our logo

Looking to use the Aetna logo on your advertising? [Start here](#).

It's a simple process. You just need to complete a quick form to request permission and get approval first. Once approved, you'll receive the logo and instructions on how to use it.

- Note: Aetna only approves requests that appropriately reflect that Aetna is among the brands you sell. Aetna is unable to approve requests that imply exclusivity or special status to sell our products.

The Aetna logo is displayed in a bold, lowercase, sans-serif font. The letters are a deep purple color. A small registered trademark symbol (®) is located at the top right of the letter 'a'.

[Table of contents »](#)

Submitting Business

Section 6

aetna[®]

6. Submitting Business

Before completing an application

Power of attorney

Medicare Supplement applications

- Guaranteed issue and 12 month trial rights
- Open Enrollment
- Underwritten applications
- Anniversary and birthday rules

Completing the application

- Choosing an effective date
- Signature date
- Application fees
- Initial draft date
- Know your bill date

Payment methods

Net billing

Telephone interview

- Final Expense Jet pre-approval interview

Final Expense Jet point of sale

Underwriting

Reasons we'll close an application

Declined applications

[Table of contents »](#)

Before completing an application

Before completing an application

You should review the policy specifics of each policy and ensure that your applicant understands the costs and benefits.

Always take enough time with your applicant to assure they fully understand all application questions and terminology.

The initial premium draft can only be processed on the policy issue or effective date. If you don't select your applicant's preference on the application, we will draft the initial premium on the issue date of the policy.

- Note: Since we use PO Boxes for new application submission, we can't accept overnight payments.

Power of attorney

If the application is underwritten, it must have the applicant's signature. A Power of Attorney may only sign an application in place of the applicant on Medicare Supplement guaranteed issue or Open Enrollment applications.

- Note: An application signed by an Attorney-in-fact (Power of Attorney) must follow this format: "John Smith, Attorney-in-fact, for Mary Smith" or "Mary Smith by John Smith, Attorney-in-fact"

6. Submitting Business

Before completing an application

Power of attorney

Medicare Supplement applications

- Guaranteed issue and 12 month trial rights
- Open Enrollment
- Underwritten applications
- Anniversary and birthday rules

Completing the application

- Choosing an effective date
- Signature date
- Application fees
- Initial draft date
- Know your bill date

Payment methods

Net billing

Telephone interview

- Final Expense Jet pre-approval interview

Final Expense Jet point of sale

Underwriting

Reasons we'll close an application

Declined applications

[Table of contents »](#)

Before completing a Medicare Supplement application

Medicare Supplement applications

Review and clarify the difference between guaranteed issue, Open Enrollment and underwritten applications.

Medicare Supplement guaranteed issue

Guaranteed issue, or trial rights, are listed in the [Choosing a Medigap Policy Booklet](#) produced by CMS.

Guaranteed issue is 63 days after loss of coverage. Submit the application within 63 days of the applicant's termination date from prior insurance.

Proof of [credible coverage](#) is required in all guarantee issue events.

- You can post-date a guaranteed issue effective date. It can be 90 days past the signature date.
- Guaranteed issue applications must be submitted with the required proof of credible coverage documentation.
- Federal and State guidelines outline eligibility for guaranteed issue applications. Please consult the Department of Insurance for qualifying events in your applicant's state.
- Plans G and N are not available for guaranteed issue applications in most states.
- All Eligibility questions must be completed. Dates and prior carrier information are required on all guaranteed issue applications.
 - If prior coverage is listed, a replacement form is required.
- Health questions should not be answered.
- Guaranteed Issue policies are issued with preferred (non-smoker) rates. State exceptions may apply.

12 month trial right situations:

- When your applicant first became eligible for benefits under Part B (or Part A in some states) of Medicare at age 65 or older, they enrolled in a Medicare Advantage plan and within the first year of joining, decided they wanted to switch to Original Medicare. – applicant is eligible for guaranteed issue.
- When your applicant was enrolled in a Medicare Supplement policy and chose to drop that policy to join a Medicare Advantage plan for the first time, and within the first year of joining, decided they wanted to switch back. – applicant is eligible for guaranteed issue for the same policy they had before if the same insurance company sells it. If their former policy isn't available, they can buy Plan A, B, C, F, K, or L from any insurance company in their state.

Continued →

6. Submitting Business

Before completing an application

Power of attorney

Medicare Supplement applications

- [Guaranteed issue and 12 month trial rights](#)
- Open Enrollment
- Underwritten applications
- Anniversary and birthday rules

Completing the application

- Choosing an effective date
- Signature date
- Application fees
- Initial draft date
- Know your bill date

Payment methods

Net billing

Telephone interview

- Final Expense Jet pre-approval interview

Final Expense Jet point of sale

Underwriting

Reasons we'll close an application

Declined applications

[Table of contents »](#)

Before completing a Medicare Supplement application (continued)

Guaranteed issue - loss of Group Medical coverage

We require a copy of the disenrollment (credible coverage) letter with:

- applicant name(s)
- applicant address
- date of termination

Guaranteed issue - loss of Medicare Advantage (MA)

For a no fault disenrollment, such as the MA leaving the area, we require:

- a completed Replacement form
- A copy of the notification from the MA with:
 - reason for disenrollment
 - the disenrollment date
 - applicant name(s)
 - applicant address

For the applicant leaving the area, we require:

- a completed Replacement form
- Documentation indicating prior address

OR

- A copy of the notification from the MA with:
 - reason for disenrollment
 - the disenrollment date
 - applicant name(s)
 - applicant address

For Misrepresentation, we require:

- a completed Replacement form
- A copy of the final judgment on the filed grievance

Continued →

6. Submitting Business

Before completing an application

Power of attorney

Medicare Supplement applications

- Guaranteed issue and 12 month trial rights
- [Open Enrollment](#)
- [Underwritten applications](#)
- Anniversary and birthday rules

Completing the application

- Choosing an effective date
- Signature date
- Application fees
- Initial draft date
- Know your bill date

Payment methods

Net billing

Telephone interview

- Final Expense Jet pre-approval interview

Final Expense Jet point of sale

Underwriting

Reasons we'll close an application

Declined applications

[Table of contents »](#)

Before completing a Medicare Supplement application (continued)

Medicare Supplement Open Enrollment

Medicare Supplement Open Enrollment is a one-time (in most instances) period when an individual can purchase any Medicare Supplement plan offered in their resident state. It begins 180 days before the policyholders Part B effective date (except Wisconsin which is 90 days before) and ends 180 days after the Part B effective date. If the policyholder takes on a Medicare disability they will receive a second Open Enrollment when they turn 65.

Open Enrollment begins on the 1st of the month in which the applicant becomes 65 and/or enrolls in Medicare Part B.

- You can post-date an open enrollment effective date. It can be 180 days past the signature date (except West Virginia which is 90 days).
- Health questions should not be answered.
- Open Enrollment policies are issued with preferred (non-smoker) rates. State exceptions may apply.

Medicare Supplement underwritten applications

Any applications that don't meet the guaranteed issue or Open Enrollment qualifications.

Underage Disability Insurance

Available only in states where we have filed and approved underage rates. For age, state, plan availability and application type (guaranteed issue, Open Enrollment or underwritten), please consult the Outline of Coverage for your applicant's state.

6. Submitting Business

Before completing an application

Power of attorney

Medicare Supplement applications

- Guaranteed issue and 12 month trial rights
- Open Enrollment
- Underwritten applications
- [Anniversary and birthday rules](#)

Completing the application

- Choosing an effective date
- Signature date
- Application fees
- Initial draft date
- Know your bill date

Payment methods

Net billing

Telephone interview

- Final Expense Jet pre-approval interview

Final Expense Jet point of sale

Underwriting

Reasons we'll close an application

Declined applications

Anniversary and birthday rules

Missouri anniversary rule:

- 60 day enrollment period, beginning 30 days prior to your applicant's policy anniversary date.
- Your applicant must choose the same plan as their current plan (F to F, G to G).
 - We need proof of current Medicare Supplement coverage that includes plan description and effective dates, such as an ID card or Schedule Page.

California and Oregon birthday rule:

California and Oregon provide a special Open Enrollment period for individuals currently enrolled in Medicare supplement plans.

- 60 day enrollment period, beginning 30 days prior to your applicant's birthday.
- Application must be signed (application signature date) within 60 day Open Enrollment period.
- Effective date must fall on birthday or up to 90 days after birthday.
- Plan benefits must be of equal or lesser value to current plan.
 - We need proof of current Medicare Supplement coverage that includes plan description and effective dates, such as an ID card or Schedule Page.
- Application must be marked as Open Enrollment (California only.)

[Table of contents »](#)

6. Submitting Business

Before completing an application

Power of attorney

Medicare Supplement applications

- Guaranteed issue and 12 month trial rights
- Open Enrollment
- Underwritten applications
- Anniversary and birthday rules

Completing the application

- Choosing an effective date
- Signature date
- Application fees
- Initial draft date
- Know your bill date

Payment methods

Net billing

Telephone interview

- Final Expense Jet pre-approval interview

Final Expense Jet point of sale

Underwriting

Reasons we'll close an application

Declined applications

[Table of contents »](#)

Completing the application

Completing the application

You can complete and submit online applications for most of our products with our E-App tool. Go to aetnaseniorproducts.com, agent side home page/E-App. Our E-App tool is the fastest way to submit new applications. It's easy and time to go paperless.

- One login – from aetnaseniorproducts.com
- Multi-device capability – runs on laptops, desktops, and tablets
- Voice and electronic signature options
- Applicant specific guidance – based on answers to questions
- In-good-order applications – key information (accurate data) required
- Submit in real time – processing begins immediately
- Rapid visibility to submitted applications – in online report in 30 minutes
- Empty your briefcase and trunk – no more loads of forms and paper

In addition to E-App, completed paper applications may be submitted by mail or fax.

Paper applications must be submitted within 30 days of the application signature date.

- Note: Final Expense applications must be submitted within 15 days from the pre-approval date.

If your applicant is paying by check, the application and check must be submitted together by mail.

- Note: Do not fax the application and mail the check.

Continued →

6. Submitting Business

Before completing an application

Power of attorney

Medicare Supplement applications

- Guaranteed issue and 12 month trial rights
- Open Enrollment
- Underwritten applications
- Anniversary and birthday rules

Completing the application

- Choosing an effective date
- Signature date
- Application fees
- Initial draft date
- Know your bill date

Payment methods

Net billing

Telephone interview

- Final Expense Jet pre-approval interview

Final Expense Jet point of sale

Underwriting

Reasons we'll close an application

Declined applications

[Table of contents »](#)

Completing the application (continued)

Complete all fields on the application – and other required forms

Applications must be signed by the primary insured (policy owner) and the spouse/domestic partner, if applicable.

- Power of Attorney signature is not acceptable except on Medicare Supplement guaranteed issue or Open Enrollment applications.

If you make corrections to the application before the application is submitted, your applicant must strike over and initial the correction. Don't use Wite-Out.

Make sure you select the coverage type, plans and optional coverage as well as the benefit amount your applicant wants to apply for.

- Note: For Final Expense applications, you will be asked to provide the requested face amount at the beginning of the pre-approval call.

If the product you're selling includes optional riders, please indicate any that your applicant does not want to apply for with N/A.

You must select the premium mode and payment method on the application.

If your applicant isn't going to pay annually, use the online rate quote tool or the modal factors in the outline of coverage or the rate guide to make sure you calculate the correct premium.

All health questions must be answered for underwritten plans.

A completed HIPAA form is required before any telephone interview.

Your Agent Writing Number and signature are required before the application is submitted.

Continued →

6. Submitting Business

Before completing an application

Power of attorney

Medicare Supplement applications

- Guaranteed issue and 12 month trial rights
- Open Enrollment
- Underwritten applications
- Anniversary and birthday rules

Completing the application

- [Choosing an effective date](#)
- [Signature date](#)
- [Application fees](#)
- Initial draft date
- Know your bill date

Payment methods

Net billing

Telephone interview

- Final Expense Jet pre-approval interview

Final Expense Jet point of sale

Underwriting

Reasons we'll close an application

Declined applications

[Table of contents »](#)

Completing the application (continued)

Choosing an effective date

All applications must contain a requested effective date.

- Cancer and Heart Attack or Stroke applications don't have a dedicated spot for the requested effective date. Please clearly indicate the requested effective date on page 2 of the application next to "Type of coverage selected".

Type of coverage selected:	
<input type="radio"/> Individual	
<input type="radio"/> Individual and spouse (or domestic partner)	
<input type="radio"/> Individual and child(ren)	
<input type="radio"/> Family	
Plan selected:	Benefit amount:

Effective dates must be on or after the signature date of the application. All dates are available with the exception of the 29th, 30th, or 31st of each month.

Underwritten applications can be submitted 90 days prior to the effective date.

Review the signature date

Signature dates can't be:

- after we receive the application
- more than 30 days before we receive the application
- after the effective date

Application fees

If a product has an application fee, it will be detailed in the outline of coverage or the rate guide.

Continued →

6. Submitting Business

Before completing an application

Power of attorney

Medicare Supplement applications

- Guaranteed issue and 12 month trial rights
- Open Enrollment
- Underwritten applications
- Anniversary and birthday rules

Completing the application

- Choosing an effective date
- Signature date
- Application fees
- [Initial draft date](#)
- [Know your bill date](#)

Payment methods

Net billing

Telephone interview

- Final Expense Jet pre-approval interview

Final Expense Jet point of sale

Underwriting

Reasons we'll close an application

Declined applications

[Table of contents »](#)

Completing the application (continued)

Initial draft date

Initial premium for electronic funds transfer will either be drafted on the day of issuance or on the effective date of the policy. If you don't select which date you'd prefer for the initial premium draft, EFT will draft on the day of policy issuance.

- For Medicare Supplement in California, only one month's premium may be accepted as the initial draft regardless of billing mode.

If the first attempt to draft the initial premium is not successful, we will make a second attempt to draft the initial premium. If the second attempt to draft the initial premium is not successful, the policy will be changed to quarterly direct bill. The policyholder will need to pay the premium in full before their policy is active. If we don't receive payment within 45 days, the policy will lapse. If the policy has lapsed, a new application and telephone interview (if applicable) are required.

Know your bill date

If your applicant wants the bill date for their policy to be different than the Initial draft date, they may request a subsequent bill date on the application at the time of submission. The bill date shouldn't be more than 15 days after the policy effective date. If it is, our system will draft the policyholder's account twice the first month to make sure the policy doesn't lapse before the next bill date.

Your applicant can't request a bill date on the 29th, 30th, or 31st of the month.

- All bill dates requested for the 29th will be drafted on the 28th of the month.
- All bill dates requested for the 30th or 31st will be drafted on the 1st of the following month.

6. Submitting Business

Before completing an application

Power of attorney

Medicare Supplement applications

- Guaranteed issue and 12 month trial rights
- Open Enrollment
- Underwritten applications
- Anniversary and birthday rules

Completing the application

- Choosing an effective date
- Signature date
- Application fees
- Initial draft date
- Know your bill date

Payment methods

Net billing

Telephone interview

- Final Expense Jet pre-approval interview

Final Expense Jet point of sale

Underwriting

Reasons we'll close an application

Declined applications

[Table of contents »](#)

Payment methods

Payment methods

Requirement for EFT Payments:

- The EFT form must be completed, signed and dated.
- If the owner of the bank account is someone other than your applicant, the bank account owner must sign where indicated on the application.
- All modes of premium may be drafted.

Requirement for direct bill payments:

- The payment should be submitted at the same time as the application.
- If not, the policy will be issued and an invoice will be sent to the policyholder.
- The policyholder will need to submit the initial payment within 30 days of the policy issue date.
- No commissions and no claims are processed until the initial payment is received.

We don't accept monthly direct bill for Final Expense premiums.

Net billing

If there is a shortage on the initial payment we'll send a bill notice to both the applicant and the agent.

If we don't receive the payment within 20 days from the issue date, we'll send a 2nd bill notice to both the applicant and the agent.

If we don't receive the payment after 30 days from the issue date, we'll close the application. Any funds we received up to that point will be refunded to the account holder in the next billing cycle. If the applicant still wants a policy, a new application is required.

6. Submitting Business

Before completing an application

Power of attorney

Medicare Supplement applications

- Guaranteed issue and 12 month trial rights
- Open Enrollment
- Underwritten applications
- Anniversary and birthday rules

Completing the application

- Choosing an effective date
- Signature date
- Application fees
- Initial draft date
- Know your bill date

Payment methods

Net billing

[Telephone interview](#)

- [Final Expense Jet pre-approval interview](#)

Final Expense Jet point of sale

Underwriting

Reasons we'll close an application

Declined applications

[Table of contents »](#)

Telephone interview

Telephone interview

Final Expense, Hospital Indemnity Flex and underwritten Medicare Supplement applications require a recorded telephone interview. The telephone interview will include a review of the health questions from the application and a prescription check.

Your applicant needs to consent to the prescription check/telephone interview. Please ensure that your applicant knows the name of the underwriting company on the application and signs the HIPAA form before the telephone interview.

- If the telephone interview isn't conducted at the time of the sale, please make sure you schedule a follow-up time for the interview with your applicant. The telephone interview will need to be scheduled within 30 days of the application submission.
- The Final Expense telephone interview is for pre-approval, and should be completed before you submit the application.

If a telephone interview cannot be completed, you must indicate the reason why in the Remarks section of the application and submit three years of medical records with the application.

Final Expense Jet pre-approval telephone interview

A quick and simple phone call at the point of sale to determine what plan your applicant qualifies for.

The Jet pre-approval team cannot provide advice to you or your applicant nor give definitions or explanations of the health questions. If your applicant needs further explanation or guidance on a health condition during the call, you will be advised to contact the home office directly. Jet pre-approval will not be able to complete the process.

- Note: Translations are available for all languages. You are not an acceptable form of translations for the telephone interview. Translations may result in a longer pre-approval telephone interview.

6. Submitting Business

Before completing an application

Power of attorney

Medicare Supplement applications

- Guaranteed issue and 12 month trial rights
- Open Enrollment
- Underwritten applications
- Anniversary and birthday rules

Completing the application

- Choosing an effective date
- Signature date
- Application fees
- Initial draft date
- Know your bill date

Payment methods

Net billing

Telephone interview

- Final Expense Jet pre-approval interview

[Final Expense Jet point of sale](#)

Underwriting

Reasons we'll close an application

Declined applications

[Table of contents »](#)

Final Expense Jet pre-approval

Final Expense Jet pre-approval point of sale steps

Call **1-877-JET-2759** (toll free). If your applicant is present, select option 1. (three-way calls are acceptable)

Outside of Jet pre-approval hours, simply determine a date/time that works for you and your applicant.

- Note: When you call Jet pre-approval at the designated time, they'll initiate the three-way call with your applicant.

If your applicant is pre-approved for the plan of choice:

- Write the provided pre-approval number on the application
- Fax us all of the completed documents
- If not using EFT, mail us the check and Final Expense payment form

If your applicant is pre-approved for a plan other than the plan of choice:

- Determine if your applicant wants to submit an application with the pre-approved plan
- Write the provided pre-approval number on the application
- Indicate the new plan and/or face amount on the application
- Have the applicant initial the change (don't use Wite-Out)
- Fax us all of the completed documents
- If not using EFT, mail us the check and Final Expense payment form

6. Submitting Business

Before completing an application

Power of attorney

Medicare Supplement applications

- Guaranteed issue and 12 month trial rights
- Open Enrollment
- Underwritten applications
- Anniversary and birthday rules

Completing the application

- Choosing an effective date
- Signature date
- Application fees
- Initial draft date
- Know your bill date

Payment methods

Net billing

Telephone interview

- Final Expense Jet pre-approval interview

Final Expense Jet point of sale

Underwriting

Reasons we'll close an application

Declined applications

Underwriting

Underwriting

Applications are underwritten up until the time the policy is issued and first premium paid. If a declinable health condition is discovered between the time the application is taken and the time the policy is issued, the application will be declinable.

Telephone interviews and/or prescription checks are required on all underwritten business.

Applications must include all pages of the application, HIPAA form, replacement form (if applicable) and any state required forms.

Power of Attorney signatures are not acceptable on any underwritten applications.

All health questions on underwritten applications must be answered completely before the application is submitted.

- Any "Yes" answer to a health question will automatically disqualify your applicant. You should not submit this application.
- Note: For Final Expense, all health questions must be completed up until a "Yes" answer is provided, if any. A "Yes" answer may not automatically disqualify your applicant. They may qualify for a different level of plan.

The health history should include a complete list of all your applicant's medications and the diagnosis for which they are prescribed. Refer to the [drug list](#) information for any unacceptable medications.

- Applications which include any of the unacceptable medications should not be submitted for consideration.

The physician information should include all the physicians your applicant has seen within the past 24 months, including primary care and any specialists. This section must include the physician's name, specialty and reason for the visit (diagnosis).

- If additional space is needed to list your applicant's medications or physician information, please use a separate piece of paper and attach it to the application.

[Table of contents »](#)

6. Submitting Business

Before completing an application

Power of attorney

Medicare Supplement applications

- Guaranteed issue and 12 month trial rights
- Open Enrollment
- Underwritten applications
- Anniversary and birthday rules

Completing the application

- Choosing an effective date
- Signature date
- Application fees
- Initial draft date
- Know your bill date

Payment methods

Net billing

Telephone interview

- Final Expense Jet pre-approval interview

Final Expense Jet point of sale

Underwriting

Reasons we'll close an application

Declined applications

[Table of contents »](#)

Closed and declined applications

Reasons we'll close an application

- The incorrect documents were submitted.
- Anyone other than the applicant supplies the answers to the questions and signs the application. Power of Attorney (POA) signing is not acceptable. (exception: Open Enrollment/Guaranteed Issue only – Attorney-In-Fact signing on behalf of applicant.)
- Affidavit of Domestic Partner Form (Georgia Cancer only) is not signed, dated and notarized.
- The applicant did not know they applied for insurance.
- The applicant does not consent to a prescription check and/or telephone interview.
- Anyone other than the applicant completes the telephone interview.
- During the telephone interview, we discover that the agent who signed the application did not speak with the applicant.
- Any health questions are unanswered or are answered "Yes".
 - Note: For Final Expense, a "Yes" answer may not automatically disqualify your applicant. They may qualify for a different level of plan.
- If the application was submitted with a check from a third-party payor that has no family (spouse/partner, child, etc.) or business relationship (business owner, employee or retiree of the business).
- We receive the application at the home office more than 30 days after the applicant's signature date.
 - For Final Expense, we must receive the application at the home office within 15 days from the pre-approval date.
- Applicant is not a legal U.S. resident.
- Multiple options were selected within the non-forfeiture options of the Final Expense application. (See Final Expense brochure for further details.)

Continued →

6. Submitting Business

Before completing an application

Power of attorney

Medicare Supplement applications

- Guaranteed issue and 12 month trial rights
- Open Enrollment
- Underwritten applications
- Anniversary and birthday rules

Completing the application

- Choosing an effective date
- Signature date
- Application fees
- Initial draft date
- Know your bill date

Payment methods

Net billing

Telephone interview

- Final Expense Jet pre-approval interview

Final Expense Jet point of sale

Underwriting

[Reasons we'll close an application](#)

[Declined applications](#)

[Table of contents »](#)

Closed and declined applications (continued)

Incomplete or unreadable applications

If the document is incomplete or illegible, the application will be closed and a clear and complete copy will need to be resubmitted.

- Illegible applications need to be submitted in a way that they're readable.
- Incomplete applications have to be completely resubmitted.

Don't use Wite-Out

Any page on the application submitted with Wite-Out is automatically closed. When you resubmit, new signature dates are required.

Declined applications

Common reasons for Medicare Supplement application decline:

- Any type of further evaluation, diagnostic testing or surgery that has not been performed, or where test results are pending.
- Any condition listed under Question 3 of the Medicare Supplement application.
- Macular Degeneration (wet) requiring injections within the past 12 months.
- Atrial Fibrillation currently being treated with any medication.
- Diabetes with heart or artery blockage at any time.
- Diabetes with any history of aneurysm, stroke or Transient Ischemic Attack (TIA).
- History of prostate cancer with a detectable Prostate Antigen (PSA) reading.
- Osteoporosis with any type of fracture, including fracture due to accidents.
- Lung or respiratory disorders: use of oxygen or a nebulizer within the past 24 months (including hospital/in home use).
- Lung or respiratory disorder with tobacco use in the past 12 months.
- Prescribed medications for conditions listed on the application. We consider this treatment for the condition.

Policyholder Experience

Section 7

aetna[®]

7. Policyholder Experience

Policyholder services

- [Sending us documentation](#)
- [Free look period](#)

Withdrawing or canceling an application

Changing policy benefit amounts

Changing Final Expense benefit amounts

Changing an effective date

Changing a bill date

Reinstatement

- Medicare Supplement
- Final Expense
- Complimentary

Canceling a policy

Refunds

Explanation of benefits (EOB)

Claims

- Medicare Supplement
- Final Expense
- Complimentary

Online tools for members

- Member secure website
- Correspondence preferences
- ID cards

[Table of contents »](#)

Policyholder services

Sending documentation to policyholder services

We can't accept certain types of information via email. You'll need to mail or fax us the following types of information:

- Death certificates
- Bank information
- Anything that includes Protected Health Information (PHI)

Free look period

The "free look period" is 30 days from the time the policyholder receives the policy. If they selected the option for E-delivery the 30 day free look period starts once the E-policy is opened.

A written request is needed to cancel within the free look period. The easiest and most accurate way to fulfil this requirement is to write "Cancel" on the policy and mail it back to us.

If your applicant indicates they wish to withdraw or cancel the application:

- If the application is in pending status, you or your applicant can call the New Business department, at **1-800-264-4000** to withdraw the application.
- If the application status is already active, you or your policyholder can notify Policyholder Services to terminate the policy.

Changing policy benefit amounts

If your policyholder would like to increase the benefit amount, they will need to submit a new application.

If your policyholder would like to decrease the benefit amount, they do not need to submit a new application.

7. Policyholder Experience

Policyholder services

- Sending us documentation
- Free look period

Withdrawing or canceling an application

Changing policy benefit amounts

Changing Final Expense benefit amounts

Changing an effective date

Changing a bill date

Reinstatement

- Medicare Supplement
- Final Expense
- Complimentary

Canceling a policy

Refunds

Explanation of benefits (EOB)

Claims

- Medicare Supplement
- Final Expense
- Complimentary

Online tools for members

- Member secure website
- Correspondence preferences
- ID cards

[Table of contents »](#)

Final Expense benefit amounts

Changing Final Expense benefit (face) amounts

Within 30 days of the application signature date:

- If your policyholder wants to increase the benefit amount:
 - Complete a new page 1 of the application indicating the new total amount
 - Your policyholder must initial the change before you submit it
 - We'll issue a new policy with the additional benefit amount as long as the combined policies don't exceed the maximum benefit level
- If your policyholder wants to decrease the benefit amount:
 - We'll need a signed, written request from your policyholder with the reason the decrease is requested
 - We'll reissue the existing policy for the new benefit amount
 - We'll apply any overpaid premiums toward future premiums

If the request is greater than 30 days from the application signature date:

- If your policyholder wants to increase the benefit amount:
 - Complete a new application and telephone interview
 - Your applicant's current age will apply
 - The new policy must meet the minimum benefit amount
 - The combined policies can't exceed the maximum benefit level
 - The two year contestability period restarts from the new policy effective date
- If your policyholder wants to decrease the benefit amount:
 - Complete a new application for the total of the desired benefit amount
 - Your applicant's current age will apply
 - We'll cancel the existing policy and issue a new policy for the new benefit amount
 - We'll refund any cash value from the cancelled policy to the policyholder
 - The two year contestability period restarts from the new policy effective date

7. Policyholder Experience

Policyholder services

- Sending us documentation
- Free look period

Withdrawing or canceling an application

Changing policy benefit amounts

Changing Final Expense benefit amounts

[Changing an effective date](#)
[Changing a bill date](#)

Reinstatement

- Medicare Supplement
- Final Expense
- Complimentary

Canceling a policy

Refunds

Explanation of benefits (EOB)

Claims

- Medicare Supplement
- Final Expense
- Complimentary

Online tools for members

- Member secure website
- Correspondence preferences
- ID cards

[Table of contents »](#)

Changing policy effective and bill dates

Changing an effective date

If your policyholder wants to change their policy effective date, we'll review the change request. You or your policyholder will need to send us a written request stating the change of effective date and the reason for the change.

- The request must be submitted within the first 60 days of the policy effective date.
- The original policy will be terminated and a new policy will be issued with the new effective date.
- Any premium payments collected will be applied to the new policy.
- If the reason for the request is because they had prior Medicare Supplement coverage, we need to receive documentation showing the effective date of the prior coverage.

Please note: If an effective date is changed after 30 days, the policyholder's two year contestability period restarts on the new effective date.

For Final Expense, *within* 30 days of the application signature date:

- A written request from your policyholder stating a reason for the change must be faxed to 877 302.3304.
- A new application is not required.

Changing a Bill Date

If your policyholder wants to change their bill date after their policy is active, they may contact our Policyholder Services department. The new bill date shouldn't be more than 15 days after the current bill date. If it is, our system will draft the policyholder's account twice the next month to make sure the policy doesn't lapse before the next bill date.

7. Policyholder Experience

Policyholder services

- Sending us documentation
- Free look period

Withdrawing or canceling an application

Changing policy benefit amounts

Changing Final Expense benefit amounts

Changing an effective date

Changing a bill date

Reinstatement

- Medicare Supplement
- Final Expense
- Complimentary

Canceling a policy

Refunds

Explanation of benefits (EOB)

Claims

- Medicare Supplement
- Final Expense
- Complimentary

Online tools for members

- Member secure website
- Correspondence preferences
- ID cards

[Table of contents »](#)

Policy reinstatement

Medicare Supplement

There will be no gap in coverage if payment is made within the state allowed timeframe.

If the policyholder does not make a payment during the state allowed timeframe, a reinstatement form may be used up to 90 days from the paid to date.

After the state allowed timeframe:

- A reinstatement form must be completed and signed
- Reinstatement will be reviewed and considered

One premium payment should be submitted with reinstatement application (if reinstatement is denied, the premium will be refunded).

Policies reinstated using a reinstatement form will have a gap in coverage (from paid to date to date of reinstatement).

After 90 days a new application is required.

Final Expense

All back premiums must be paid in order to reinstate the policy within 60 days of the paid to date.

No reinstatement form is required.

Complimentary products

To reinstate a policy for one of our other products, you'll need to submit a new application for your policyholder. Indicate on the application that you're submitting it for a reinstatement.

7. Policyholder Experience

Policyholder services

- Sending us documentation
- Free look period

Withdrawing or canceling an application

Changing policy benefit amounts

Changing Final Expense benefit amounts

Changing an effective date

Changing a bill date

Reinstatement

- Medicare Supplement
- Final Expense
- Complimentary

[Canceling a policy](#)

[Refunds](#)

[Explanation of benefits \(EOB\)](#)

Claims

- Medicare Supplement
- Final Expense
- Complimentary

Online tools for members

- Member secure website
- Correspondence preferences
- ID cards

[Table of contents »](#)

Canceling and refunds

Canceling a policy

If your policyholder wants to cancel their policy, you or your policyholder will need to send us a written request with your policyholder's name, policy number, signature and the date your policyholder wants cancellation to take effect.

- In order to backdate a Medicare Supplement cancellation, your policyholder needs to send us proof of prior Medicare Supplement coverage showing effective dates.
- If your policyholder is moving to another carrier, they must contact that carrier. We cannot cancel on their behalf.

Refund guidelines

Before we can issue a refund for premiums, any pending payment must clear. Refunds are always mailed in the form of a paper check. Even if your policyholder is set up for EFT, we are not able to deposit money back into a bank account.

- Allow 15 days for an EFT payment to clear (this is in place so last premium payment can clear first)
- Allow 20 days for a paper check or money order to clear

Explanation of benefits (EOB)

EOBs are available weekly on our website www.aetnaseniorproducts.com and are mailed monthly to our policyholders.

Your policyholder can opt out of paper delivery via the secure policyholder website.

7. Policyholder Experience

Policyholder services

- Sending us documentation
- Free look period

Withdrawing or canceling an application

Changing policy benefit amounts

Changing Final Expense benefit amounts

Changing an effective date

Changing a bill date

Reinstatement

- Medicare Supplement
- Final Expense
- Complimentary

Canceling a policy

Refunds

Explanation of benefits (EOB)

Claims

- [Medicare Supplement](#)
- [Final Expense](#)
- [Complimentary](#)

Online tools for members

- Member secure website
- Correspondence preferences
- ID cards

[Table of contents »](#)

Policyholder claims

We complete a medical review before processing claims when your policyholder submits a claim where the date(s) of service are within two years of the effective date of the policy.

Medicare Supplement claims

All Medicare Supplement claims must be submitted through Medicare; we cannot process payment from balance due statements.

Liability: Our liability is based on Medicare's approved and eligible charges. If Medicare has no coverage, then the secondary plan has no liability.

Appeals: If your policyholder does not agree with the way Medicare processed a claim, they need to appeal directly to Medicare.

Plans G & N: these specific plan types have certain patient responsibility components that are not covered as part of the Medicare Supplement plan.

If your policyholder has a name change, they'll need to change their name with Medicare first and then call us to change it. We won't update our records unless they match Medicare. When the records don't match, it will cause an error with crossover claims.

Life claims

Notice of a life claim can be made by submitting a death certificate or calling in to report the death. We'll then send a packet to the beneficiary to start the process.

If the death occurs within the two year contestable period, we will conduct a claims investigation into the insured's health condition.

Policy will be rescinded for material misrepresentation pursuant to state law.

Complimentary product claims

A claim for services must be submitted for claims reimbursement.

- Always include the policy number on submitted claims.
- Please sign and return a HIPAA information release form.

We don't pay claims for services that haven't happened yet. If a policyholder pre-pays a provider for services, the claims for those services can't be processed until the service is actually provided.

7. Policyholder Experience

Policyholder services

- Sending us documentation
- Free look period

Withdrawing or canceling an application

Changing policy benefit amounts

Changing Final Expense benefit amounts

Changing an effective date

Changing a bill date

Reinstatement

- Medicare Supplement
- Final Expense
- Complimentary

Canceling a policy

Refunds

Explanation of benefits (EOB)

Claims

- Medicare Supplement
- Final Expense
- Complimentary

Online tools for members

- Member secure website
- Correspondence preferences
- ID cards

[Table of contents »](#)

Online tools for policyholders

Member secure website

Our website is located at www.aetnaseniorproducts.com. From this homepage your policyholders can review general information about our products and services.

All Aetna Senior Supplemental insurance policyholders can login (after initial sign-up) to the secure member side of our website.

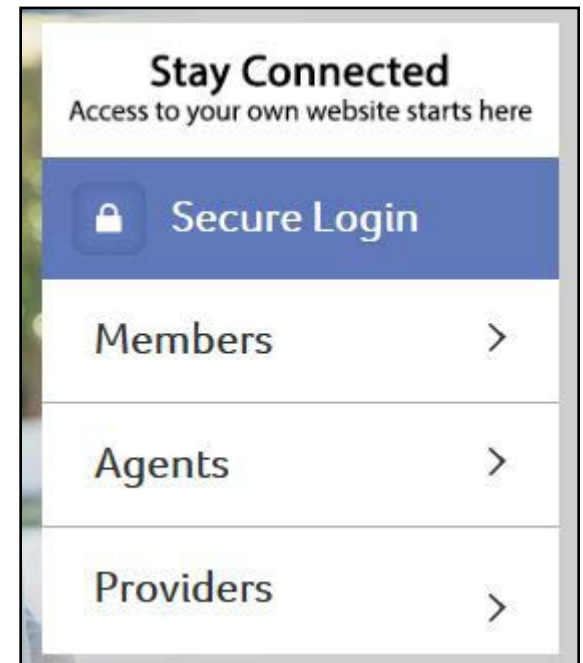
Once they've logged in, your policyholder:

- view policy details and claims
- access member discounts
- request duplicate ID cards and policy pages
- update contact and bank information
- send department specific requests

Member secure login

Under the Secure Login section your policyholder can click on "Members" and sign in with the User Name and Password they created.

If this is the first time they've used our website, they can simply click on the "Register Now" button to register their account. The sign-up process is quick and simple, but just in case technical assistance is required, we have a dedicated web assistance team that provides website related technical assistance.



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7. Policyholder Experience

Policyholder services

- Sending us documentation
- Free look period

Withdrawing or canceling an application

Changing policy benefit amounts

Changing Final Expense benefit amounts

Changing an effective date

Changing a bill date

Reinstatement

- Medicare Supplement
- Final Expense
- Complimentary

Canceling a policy

Refunds

Explanation of benefits (EOB)

Claims

- Medicare Supplement
- Final Expense
- Complimentary

Online tools for members

- Member secure website
- [Correspondence preferences](#)
- [ID cards](#)

[Table of contents »](#)

Online tools for policyholders

Correspondence preference

Once the policyholder is logged in to the secure website, they can click on “My Notifications” on the left side of the screen.

Next they will click on the link on the right side that says Correspondence/Alert Preference and then click on Correspondence Preference.

Once there just click on the Receive Electronic Correspondence button to receive EOB's through the email they have set up on file.

ID cards

ID cards are available for Medicare Supplement policies only.

A temporary Medicare Supplement ID card is available to view, download, or print from our website.

All other products don't require an ID card since the benefits are paid to the policyholder. For some of our products, we offer the ability to print a card that includes the policy number and basic claim submission information.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).