Attestation:

- Specified Disease Buyer's Guide
- Additional Beneficiaries

AdventHealth **802628**

INFORMATION ABOUT YOU. Fax completed form(s) to: (407) 599-0550
Mail completed forms to: CustomerserviceWP@usenrollments.com

Print your name (first, middle initial, last)	Social Security Number	Date of birth (MM/DD/YYYY)

Read This Page Carefully

As the employee, you must complete, sign and submit this form to your employer.

1. ***Utah, Maine and New Hampshire Policy Members & Residents:*** Have you received a copy of the Specified Disease Buyer's Guide? ☐ Yes ☐ No

If your beneficiaries are the same for each product (Accident, Critical Illness and Hospital Indemnity), please check here and ***only*** enter your beneficiary information ***once***. ☐ Yes ☐ No

2. Please list Beneficiaries for the Accident plan(s). You can list up to five beneficiaries per product. **The percent grand total must equal 100% and cannot be greater than or less than 100%.**

a. Beneficiary (please print): % amount for Beneficiary:

Beneficiary Type: Address:

Relationship: Social Security Number:

Date of birth: Gender:

b. Beneficiary (please print): % amount for Beneficiary:

Beneficiary Type: Address:

Relationship: Social Security Number:

Date of birth: Gender:

c. Beneficiary (please print): % amount for Beneficiary:

Beneficiary Type: Address:

Relationship: Social Security Number:

Date of birth: Gender:

d. Beneficiary (please print): % amount for Beneficiary:

Beneficiary Type: Address:

Relationship: Social Security Number:

Date of birth: Gender:

e. Beneficiary (please print): % amount for Beneficiary:

Beneficiary Type: Address:

Relationship: Social Security Number:

Date of birth: Gender:

3. Please list Beneficiaries for the Critical Illness plan(s). You can list up to five beneficiaries per product. **The percent grand total must equal 100% and cannot be greater than or less than 100%.**

a. Beneficiary (please print): % amount for Beneficiary:

Beneficiary Type: Address:

Relationship: Social Security Number:

Date of birth: Gender:

b. Beneficiary (please print): % amount for Beneficiary:

Beneficiary Type: Address:

Relationship: Social Security Number:

Date of birth: Gender:

c. Beneficiary (please print): % amount for Beneficiary:

Beneficiary Type: Address:

Relationship: Social Security Number:

Date of birth: Gender:

d. Beneficiary (please print): % amount for Beneficiary:

Beneficiary Type: Address:

Relationship: Social Security Number:

Date of birth: Gender:

e. Beneficiary (please print): % amount for Beneficiary:

Beneficiary Type: Address:

Relationship: Social Security Number:

Date of birth: Gender:

4. Please list Beneficiaries for the Hospital Indemnity plan(s). You can list up to five beneficiaries per product. **The percent grand total must equal 100% and cannot be greater than or less than 100%.**

a. Beneficiary (please print): % amount for Beneficiary:

Beneficiary Type: Address:

Relationship: Social Security Number:

Date of birth: Gender:

b. Beneficiary (please print): % amount for Beneficiary:

Beneficiary Type: Address:

Relationship: Social Security Number:

Date of birth: Gender:

c. Beneficiary (please print): % amount for Beneficiary:

Beneficiary Type: Address:

Relationship: Social Security Number:

Date of birth: Gender:

d. Beneficiary (please print): % amount for Beneficiary:

Beneficiary Type: Address:

Relationship: Social Security Number:

Date of birth: Gender:

e. Beneficiary (please print): % amount for Beneficiary:

Beneficiary Type: Address:

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Attestation: 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 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.

Employee name (please print)

Employee signature

Today's date (MM/DD/YYYY)

Non-Discrimination Notice

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Aetna provides free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, call 1-888-772-9682.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512
1-800-648-7817, TTY: 711, Fax: 859-425-3379, CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Availability of Language Assistance Services

TTY: 711

For language assistance in your language call 1-888-772-9682 at no cost. (English)

Para obtener asistencia lingüística en su idioma, llame sin cargo al 1-888-772-9682. (Spanish)

欲取得以您的語言提供的語言協助，請撥打1-888-772-9682，無需付費。(Chinese)

Pour une assistance linguistique dans votre langue, appeler le 1-888-772-9682 sans frais. (French)

Para sa tulong sa inyong wika, tumawag sa 1-888-772-9682 nang walang bayad. (Tagalog)

Hilfe oder Informationen in deutscher Sprache erhalten Sie kostenlos unter der Nummer 1-888-772-9682. (German)

للمساعدة اللغوية بلغتك الرجاء الاتصال على الرقم المجاني 1-888-772-9682. (Arabic)

Pou jwenn asistans nan lang pa w, rele nimewo 1-888-772-9682 gratis. (French Creole)

Per ricevere assistenza nella sua lingua, può chiamare gratuitamente il numero 1-888-772-9682. (Italian)

日本語で援助をご希望の方は 1-888-772-9682（フリーダイアル）までお電話ください。(Japanese)

본인의 언어로 통역 서비스를 받고 싶으시면 비용 부담 없이 1-888-772-9682번으로 전화해 주십시오. (Korean)

برای راهنمایی به زبان شما با شماره 1-888-772-9682 بدون هیچ هزینه ای تماس بگیرید. (Persian)

Aby uzyskać pomoc w swoim języku, zadzwoń bezpłatnie pod numer 1-888-772-9682. (Polish)

Para obter assistência no seu idioma, ligue gratuitamente para o 1-888-772-9682. (Portuguese)

Чтобы получить помощь с переводом на ваш язык, позвоните по бесплатному номеру 1-888-772-9682. (Russian)

Để được hỗ trợ ngôn ngữ bằng ngôn ngữ của bạn, hãy gọi miễn phí đến số 1-888-772-9682. (Vietnamese)