



Oklahoma Professionals Insurance Trust

Oklahoma Bar Association (OBA)

Applicant's Social Security Number

OBA Membership Number

- Application must be completed by the applicant in blue or black ink. **(A photocopy of this Application will not be accepted.)**
- Signature and date is required on **Page 6, Section M** for all applicants including spouse and children age 18 and over.
- PPO products are underwritten by Aetna Life Insurance Company.
- Any family member currently pregnant (whether or not listed on this Application) or in the process of adoption or surrogacy does not qualify for this program.

Send completed Application to:

Beale Professional Services
 Association Insurance Plans
 P.O. Box 60809
 Oklahoma City, OK 73146

A. Applicant Information

Name _____			Maiden Name of Applicant/Spouse _____		
Home Address (Required) - Include Apartment Number, if applicable. Number, Street _____ County _____ City, State, ZIP Code _____			Billing Address (if different from your home address above; Required) - Include Apartment Number, if applicable. Number, Street _____ County _____ City, State, ZIP Code _____		
Telephone Numbers Home () _____		Work () _____		Cell () _____	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Occupation _____		Do you read and write English? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is any person listed on this Application a "non-citizen resident" of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes", has that person(s) resided within the United States for the past six (6) consecutive months? <input type="checkbox"/> Yes <input type="checkbox"/> No		Reason for Application <input type="checkbox"/> New Application <input type="checkbox"/> Add Spouse/Dependent Child <input type="checkbox"/> Add Dependent Child Only <input type="checkbox"/> Change Existing Benefit Plan	
E-mail Address (optional) _____					

B. Coverage/Billing Selection - Please print clearly, using blue or black ink. (Shaded sections for Plan Sponsor/Aetna Use Only.)

Control/Group No. 861331	Suffix 10	Account	Plan No.	Class Code
Medical Options – Check one. Aetna Open Choice PPO: <input type="checkbox"/> \$500 Individual/\$1,000 Family Deductible <input type="checkbox"/> \$1,000 Individual/\$2,000 Family Deductible <input type="checkbox"/> \$2,500 Individual/\$5,000 Family Deductible Aetna Open Choice PPO (HSA Compatible): <input type="checkbox"/> Applicant Only Coverage <input type="checkbox"/> \$1,500 Deductible <input type="checkbox"/> \$3,000 Deductible <input type="checkbox"/> \$5,000 Deductible			Billing Options – Check one. <input type="checkbox"/> Monthly Draft (Requires Pre-Authorized Checking (PAC) Request) <input type="checkbox"/> Quarterly Premium Notice	
<input type="checkbox"/> Family Coverage-Applicant and Spouse/child(ren) <input type="checkbox"/> \$3,000 Family Deductible <input type="checkbox"/> \$5,950 Family Deductible <input type="checkbox"/> \$10,000 Family Deductible				

C. Individuals to be Covered

(Dependent children are covered up to age 21; and between the ages of 21 to 25 with proof of full-time student status.)

Check here if more space is needed to provide information on additional dependents. Use a separate sheet of paper and staple to the back of this Application.

Family Code*	Name Last	First	M.I.	Social Security Number	Date of Birth MM / DD / YYYY	Age	Sex M/F	Height (ft / in)	Weights (lbs)	Full-time Student Age 21 or older
APP										N/A
SP										N/A
01										<input type="checkbox"/> Yes <input type="checkbox"/> No
02										<input type="checkbox"/> Yes <input type="checkbox"/> No
03										<input type="checkbox"/> Yes <input type="checkbox"/> No

D. Dependent Information

Do you claim all children listed above who are between the ages of 21 to 25 as dependents on your Federal Income Tax? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, any child between the ages of 21 to 25 who is not claimed on your Federal Income Tax is NOT eligible as a dependent.
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E. Other Insurance - Please attach copy of Continuation of Coverage Certificate letter for each person, if applicable

Are you replacing existing coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently have any health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are your spouse/children covered also? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has any person ever filed a claim and/or received benefits from disability insurance or Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are any family members listed above currently enrolled in an Aetna Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide names and relationship _____ ID No. _____		If Yes, provide dates and details	
Provide name of current (or most recent) health care carrier and coverage termination date (if applicable). Name _____ Term Date _____			
Has any person listed on this Application ever been declined, postponed, had a waiver applied or charged an additional premium for life, disability or health insurance or had such insurance rescinded? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide the following information: Name: _____ Explanation: _____			
Are any persons listed above eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____			

F. Health History for Applicants and Their Dependents (Include information for all persons applying for coverage.)

Answer all questions & provide complete details to all "Yes" answers on Page 4, Section H.		Missing information may delay processing this Application.
In the past five (5) years, has any person listed on this Application been diagnosed or treated by a health care provider (including prescription medications) or been hospitalized for any of the following conditions or diseases listed in Sections F and G.		
F1.	Eyes, Ears, Nose and Throat Conditions/Disorders: Eyes/sight: glaucoma, cataracts, crossed eyes, detached retina, corneal transplant, infections; Ears/Hearing: loss of hearing, deafness, infections, eustachian tube dysfunction; Nose/breathing: deviated septum, polyps, adenoiditis, sinusitis; Throat/Swallowing: tonsillitis, strep throat, excessive snoring or sleep apnea, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F2.	Skin Conditions/Disorders: Acne, birthmarks, dermatitis, eczema, fungal infections, psoriasis, keratosis, warts, moles, pre-cancerous lesions, skin cancer or melanoma, 2nd or 3rd degree burns, herpes, scars/keloid, or revisions of cosmetic or reconstructive surgery, excessive sweating, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F3.	Musculoskeletal Conditions/Disorders: Disorders or injuries of bones, joints, muscles, ligaments, tendons or discs such as strain/sprain, fracture, arthritis, fibromyalgia, gout, herniated disc, joint replacement, internal/external fixations, permanent hardware, amputation/prosthesis, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F4.	Respiratory Conditions/Disorders: Allergies, sinusitis, bronchitis, asthma, pneumonia, shortness of breath, chronic cough, collapsed lung, emphysema, COPD, tuberculosis, fungal infections, difficulty breathing, spitting/coughing up blood, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F5.	Digestive Conditions/Disorders: Infections of mouth/throat/tonsils, problems with jaw or chewing, ulcers, hernia, gastric reflux, colitis, Crohn's Disease, Irritable Bowel Syndrome (IBS), chronic diarrhea, intestinal problems, colon polyps, rectal bleeding or hemorrhoids, diseases of the pancreas, liver or gallbladder, hepatitis A/B/C/other, jaundice, Cirrhosis, unexplained weight loss or gain, eating disorder, Gastric Bypass/Banding, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F6.	Urinary Conditions/Disorders: Bladder infections, kidney infections, stones, blood in urine, stress incontinence, urinary frequency, painful/difficult urination, cystitis, bed wetting, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F7.	Heart and Circulatory Conditions/Disorders: Anemia, bleeding/clotting disorders, Hemophilia, thrombocytopenia, varicose/spider veins, Raynauds, phlebitis, thrombosis, enlarged lymph nodes or lymphadenitis, chest pain, angina, high/low blood pressure, hypertension, high cholesterol/lipids, heart murmur, palpitations, congestive heart failure, coronary artery disease, aneurysm, heart attack, bypass surgery/angioplasty, valve replacement, pacemaker or defibrillator, rheumatic fever, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F8.	Metabolic and Endocrine Conditions/Disorders: Diabetes, adrenal/pituitary disorders, lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis, thyroid disorders, AIDS/ARC, or any immune disorder, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F9.	Brain/Nervous System Conditions/Disorders: Loss of consciousness, fainting, dizziness, numbness/tingling, weakness, paralysis, confusion, memory loss, Alzheimer's, dementia, head injury, stroke, migraine or chronic/severe headaches, narcolepsy, sleep apnea, tremors, multiple sclerosis, seizures/epilepsy, Muscular Dystrophy and Reflex Sympathetic Dystrophy (RSD), etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F10.	Male Reproductive Conditions/Disorders: Fertility/Infertility, low sperm count, sexual dysfunction, erectile dysfunction, enlarged prostate, prostatitis, undescended testes, genital or anal herpes/warts or sexually transmitted diseases, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F11.	Female Reproductive Conditions/Disorders: a) Pelvic pain, abnormal menstrual bleeding, absence of menstruation, abnormal PAP smear, endometriosis, ovarian cysts, uterine fibroids, fertility/infertility, miscarriage, breast cysts/lumps/fibroids, breast implants, genital warts/herpes or sexually transmitted diseases, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b) Has it been more than 40 days since any female listed above had her last menstrual period? If Yes, provide name(s) and reason: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c) Has any female had an abnormal PAP Smear? If Yes, provide details in H1. Name _____ Date of Last Normal Pap Smear _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

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F. Health History for Applicants and Their Dependents (Continued)

	d) Is any female listed on this Application pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate? If Yes, provide name: Name _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
F12.	Nervous, Mental and Behavioral: Depression, anxiety, attention deficit, chemical imbalance, bi-polar, obsessive-compulsive or panic disorders, substance abuse, eating disorders, counseling or support group, alcohol or chemical dependence, anorexia/bulimia, schizophrenia, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F13.	Cancer/Tumors: Cysts, tumors or abnormal growths, Hodgkin's disease, leukemia or any other cancer or malignancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F14.	Birth Defects/Congenital Abnormalities: Birthmarks, cleft palate/lip, club foot, webbed fingers/toes, developmental delay, mental retardation, Down's syndrome, heart/lung/kidney malformation, skull /facial or other physical deformities, Cerebral Palsy, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F15.	Other Conditions: Has any person listed on this Application consulted with or received treatment from any doctor or other health care provider for any other condition or symptom(s) not listed on this Application?	<input type="checkbox"/> Yes <input type="checkbox"/> No
NOTE: Medical conditions that occur after the signature date and before the effective date of the coverage if approved will be considered in the final underwriting decision. You shall communicate any medical condition occurring during such period.		

G. Health Related Questions (Include information for all persons applying for coverage.)

Answer all questions & provide complete details to all "Yes" answers on Page 4, Section H.		Missing information may delay processing this Application.
G1.	Is any male listed on this Application expecting a child or in the process of adoption or surrogacy with anyone whether or not that person is applying for coverage on this Application? If Yes, provide name below. Name _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
G2.	Has any person been treated or diagnosed for alcohol, chemical or substance abuse or been advised to reduce alcohol intake? If Yes, provide name(s) below. Name _____ Date Discontinued _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
G3.	Has any person ever used illegal or controlled drugs or substances, such as marijuana, cocaine, methamphetamines, illegal or IV drugs? If Yes, provide name(s) below. Name _____ Type of Drug/Substance _____ Date Discontinued _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
G4.	Has any person consumed any alcoholic beverage in the last 6 months? (Amount: A drink is 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor.) Name _____ Type _____ Amount _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month	<input type="checkbox"/> Yes <input type="checkbox"/> No
G5.	Has any person been convicted of a DUI (drunk driving violation)? If Yes, provide name(s), state(s) and date(s)? Name _____ State _____ Date _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
G6.	Has any person been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or tested positive for HIV (Human Immunodeficiency Virus)? Name _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
G7.	Has any person had any abnormal lab results, X-rays, MRI or other diagnostic test results or physical exam results?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G8.	Has any person been medically advised to undergo further medical testing, treatment or surgery which has not yet been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G9.	Has any person been a patient in an outpatient clinic, hospital, surgical center, treatment center or other medical facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G10.	Has any person seen any health care provider for any condition, signs or symptoms which have not yet been diagnosed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G11.	Has any person smoked or used any tobacco products, such as Snuff and/or chewing tobacco, in the last 2 years? If Yes, provide name(s) below. Name _____ Date Stopped _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Continued

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G. Health Related Questions (Continued)

G12.	Has any person taken prescription medications or been advised to take prescription medications in the last 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G13.	Has any person ever seen, received treatment from or consulted any health care provider for any other condition or symptom(s) not listed on this Application?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G14.	Is any person a candidate for, or a recipient of an organ, bone marrow or stem cell transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G15.	Is any person currently on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

H. Detailed Health Information

Check here if additional space is needed. Use a separate sheet of paper and staple to the back of this Application.

1. Provide COMPLETE DETAILS to ALL questions answered "Yes" in Sections F and G.

Family Code*	Ques. No.	Dates From	To	Explain Nature of Illness/Condition	Describe Treatment Received/Recommended and Any Limitations if Applicable	% of Recovery

2. List all prescription medications and/or doctors samples taken by you and your named dependents within the last 2 years.

Family Code*	Ques. No.	Date Prescribed (Mo/Day/Year)	Date Discontinued (Mo/Day/Year)	Name of Medication	Dosage and Frequency	Reason/Condition

3. For details and medications indicated above, please list ALL doctors, medical attendants, or practitioners you and/or any named dependents consulted. If none, please state "None."

Family Code*	Question Number and/or Reason	Name, Address and Phone Number of Attending Physician

4. List last doctor visit for all family members, including routine check-ups.

Family Code*	No Visit	Purpose of Visit	Date of Visit	Results of Visit		Name, Address and Phone Number of Physician
				Normal	Abnormal: Give Details	
APP						
SP						
01						
02						
03						

*See Page 1, Section C.

I. Statement of Application Conditions

Each member of the family will be medically underwritten separately and assigned a separate medical coverage based on their own health risk. If one or more family members are not approved, Aetna will cover the approved family members unless indicated below:

I, the applicant, instruct Aetna not to cover any eligible family members unless all family members are approved for coverage.

I prefer to receive written communication regarding my Application via email.

J. Important Applicant Information Please Read Carefully

- Coverage may be declined, or a premium adjustment made, based on information provided to Aetna during the Application process. In the case of declination, you will receive a letter notifying you that your Application has not been accepted. Specific details will be kept confidential. If all members on the Application are denied coverage, any premium payment will be returned directly to the applicant.
- Do not cancel other coverage presently in force until written notification is received from Aetna indicating that your Application has been approved and you and covered dependents are in receipt of your member ID card(s) providing the effective date of coverage.
- No coverage will become effective prior to the signature date on this application nor will coverage become effective more than 90 days after the signature date on this application.

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K. Instructions

Please review these instructions.

- The applicant must complete the Application. You are responsible to ensure that the information on the Application is correct, complete and truthful.
- Print clearly using blue or black ink. No pencil or correction fluid, please.
- Aetna must receive this Application within thirty (30) days from the signature date.
- Any misrepresentation of information on the Application may result in cancellation of coverage.
- Your insurance will become effective only if this Application is approved as applied for and the appropriate premium has been received by Aetna.
- **To avoid delays in underwriting, please review for:**
 - Missing or incomplete information such as:
 - o Weight AND Height
 - o Date of birth
 - o Physician address and phone number
 - Incomplete mailing address information including city, state, and ZIP code.
 - Incomplete answers to all Application sections. If a Health Question does not apply to you, the answer should be "No."
- If additional information or explanation is necessary, attach extra sheets. **All attachments must be signed and dated.**

You are ineligible for coverage if applicant is currently pregnant (whether or not listed on the Application) or in the process of adoption; or any non-citizen applicant has not resided in the U.S. for the last six (6) consecutive months.

Coverage is not guaranteed until approved by Aetna. Do not cancel your current insurance coverage until you have been notified of approval by Aetna and your Aetna coverage is effective.

L. Conditions and Agreement, Signature(s) Required

IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN. By filing this Application and applying for this coverage, I on behalf of myself and the dependents listed on this Application, agree to or with the following:

1. Aetna may decline this Application. No coverage comes into effect until Aetna approves this Application.
2. Coverage and benefits once they come into effect are contingent on timely and accurate payment of premiums and any other cost sharing as outlined in the policy. If premiums are not paid on time and accurately, your coverage will be terminated. I agree to make co-payments and any other cost sharing as provided for in my policy, directly to providers of health care
3. I authorize Aetna to request my and/or my dependents' (those who are applying for coverage under this Application) medical records, any prescribed medication history and any other medical or pharmaceutical information to process my Application and to make a decision on the approval or disapproval of my and/or my dependents' Application. I authorize any physician, other healthcare professionals, hospitals, clinics, labs, pharmacies, pharmacy benefit managers or any other healthcare organization ("Providers") that provided treatment or any other service to me or any of my dependents applying for coverage under this Application to disclose the information required by Aetna and described above to Aetna and/or its designated agents.
 The existence of such information and documentation as described above shall be disclosed under this Application. I understand that Aetna will rely on such information to: 1) underwrite this Application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations for all of the applicants; 2) administer claims and determine or fulfill responsibility for coverage and provisions of benefits; 3) administer coverage; and 4) conduct other insurance operations according to federal and state laws and regulations.
 I further authorize Aetna to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities.
 I understand that this authorization is provided under state law and regulations. This authorization will remain valid for the term of the coverage and if so long thereafter as allowed by law. I understand that Aetna will comply with the HIPAA Privacy Rules and that disclosure of information will be done under the rules of such Federal law.
 I understand and agree that Aetna will use any information supplied in this Application prior to the effective date of coverage in considering my Application, including any medical information.
 I understand that I am entitled to receive a copy of this authorization upon request, and that a photocopy is as valid as the original.
4. I have an obligation of communicating to Aetna in writing any medical conditions which occur to myself or to any of my dependents listed in this Application after the signature of this Application and before the effective date of the coverage if approved
5. I understand and agree that, with the exception of Aetna Rx Home Delivery, all participating providers and vendors are independent contractors and are neither insurance producers nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
6. Information on agent's compensation is available from your agent or at Aetna.com.
7. Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals for the purpose misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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**M. Signature(s) Required - All applicants and dependents age 18 and older must sign and date below.
If applicant is a minor, the Application must be signed by a parent or legal guardian.**

By signing below, I acknowledge that I have personally read, understand and agree to the terms and conditions on all the pages of this form and accept the use of binding arbitration.

I represent that all information supplied on this form is true, complete and correctly recorded by me. I have myself read, understand and agree to the conditions of enrollment on this Application. I understand that the information supplied in this form will be decisive for the approval of my Application and that any misrepresentation and/or mistake in such information will be reason for cancellation/termination of the coverage for which I am applying.

I UNDERSTAND THAT IF MY SIGNATURE/DATE DOES NOT APPEAR AND/OR ARE NOT CURRENT AND/OR MY ANSWERS ARE INCOMPLETE, my Application will be denied.

Once you submit this Application, you may be contacted at any time via telephone by an Aetna representative to complete your Application and the underwriting process. You will be able to confirm the identity of the person calling. Please do not answer any questions if you are not satisfied with the identity of the caller. The person calling will give you a number to confirm their identity. Please call if you have any doubts or problems with respect to the call or the process during the call.

Applicant/Parent or Legal Guardian Signature	Today's Date	Applicant/Spouse Signature	Today's Date
Applicant's Dependent (Not a minor)	Today's Date	Applicant's Dependent (Not a minor)	Today's Date