

STATE BAR OF TEXAS INSURANCE TRUST
Aetna Health Plan Information Request

For More Information

The Trust's service office staff in Austin is dedicated to helping with all aspects of your coverage. The Trust and Aetna are ready to assist all Members of the State Bar of Texas with their health insurance needs. We hope you will contact the State Bar of Texas Insurance Trust whenever you have any questions or concerns regarding your coverage.

To request coverage under a medical plan and/or a Hospital Daily Benefit Plan, please provide the information below. Complete the Plan Selection Form as well as the enclosed Individual Health Statement for each family member. Return all forms to the address below. Please do not send money at this time. You will receive a statement after your coverage is approved.

State Bar of Texas Insurance Trust
206 E. 9th Street, Suite 1501
Austin, Texas 78701
Phone 1-800-460-7248
Fax 1-512-479-4109

Your name _____

Telephone _____ **Fax** _____

Street address _____

City _____ **State** _____ **ZIP** _____

E-Mail Address: _____

State Bar of Texas Bar card number _____

Coverage requested for: Self Self and spouse Self and children Self and family

HOSPITAL DAILY BENEFIT PLAN SELECTION FORM

Please check the Hospital Daily Benefit Plan for which you are requesting coverage:

- | | |
|--|---|
| <input type="checkbox"/> Hospital Daily Benefit Plan J | \$50 each day of a hospital confinement beginning on the 1 st day of confinement, up to 365 days. |
| <input type="checkbox"/> Hospital Daily Benefit Plan K | \$100 each day of a hospital confinement beginning on the 1 st day of confinement, up to 365 days. |
| <input type="checkbox"/> Hospital Daily Benefit Plan L | \$150 each day of a hospital confinement beginning on the 1 st day of confinement, up to 365 days. |
| <input type="checkbox"/> Hospital Daily Benefit Plan M | \$50 each day of a hospital confinement beginning on the 8 th day of confinement, up to 365 days. |
| <input type="checkbox"/> Hospital Daily Benefit Plan N | \$100 each day of a hospital confinement beginning on the 8 th day of confinement, up to 365 days. |
| <input type="checkbox"/> Hospital Daily Benefit Plan O | \$150 each day of a hospital confinement beginning on the 8 th day of confinement, up to 365 days. |

HEALTH PLAN SELECTION FORM

Please check the Health Plan for which you are requesting coverage:

Plan**Brief Description**

Three Traditional Choice Plans

- | | |
|--|---|
| <input type="checkbox"/> Traditional Choice Indemnity Plan D | \$1,500 per person deductible; \$500 per hospital confinement deductible.
Plan pay 80%. \$5,000 per person out-of-pocket maximum. |
| <input type="checkbox"/> Traditional Choice Indemnity Plan E | \$3,000 per person deductible; \$500 per hospital confinement deductible.
Plan pay 80%. \$5,000 per person out-of-pocket maximum. |
| <input type="checkbox"/> Traditional Choice Indemnity Plan F | \$5,000 per person deductible; \$500 per hospital confinement deductible.
Plan pays 80%. \$6,000 per person out-of-pocket maximum. |

Four Open Choice PPO Plans

- | | |
|--|---|
| <input type="checkbox"/> Open Choice PPO Plan H
90/70 | <i>In-Network care:</i> \$20 copay. \$500 individual/\$1,500 family deductible.
Plan pays 90%. \$1,000 individual/\$2,000 family out-of-pocket maximum.
<i>Out-of-Network:</i> \$500 individual/\$1,500 family deductible. Plan pays 70%.
\$2,000 individual/\$4,000 family out-of-pocket maximum.
<i>Prescription Drug:</i> \$15/\$25/\$40 copay plan. |
| <input type="checkbox"/> Open Choice PPO Plan I
80/60 | <i>In-Network care:</i> \$25 copay. \$750 individual/\$2,250 family deductible.
Plan pays 80%. \$2,000 individual/\$4,000 family out-of-pocket maximum.
<i>Out-of-Network:</i> \$750 individual/\$2,250 family deductible. Plan pays 60%.
\$4,000 individual/\$8,000 family out-of-pocket maximum.
<i>Prescription Drug:</i> \$15/\$25/\$40 copay plan. |
| <input type="checkbox"/> Open Choice PPO Plan P
75/60 | <i>In-Network care:</i> \$25 copay. \$1,500 individual/\$4,500 family deductible.
Plan pays 75%. \$3,750 individual/\$7,500 family out-of-pocket maximum.
<i>Out-of-Network:</i> \$1,500 individual/\$4,500 family deductible. Plan pays 60%.
\$7,500 individual/\$15,000 family out-of-pocket maximum.
<i>Prescription Drug:</i> \$20/\$30/\$50 copay plan. |
| <input type="checkbox"/> Open Choice PPO Plan Q
70/50 | <i>In-Network care:</i> \$25 PCP copay. \$35 SCP copay,
\$2,000 individual/\$6,000 family deductible.
Plan pays 70%. \$5,000 individual/\$10,000 family out-of-pocket maximum.
<i>Out-of-Network:</i> \$2,000 individual/\$6,000 family deductible. Plan pays 50%.
\$10,000 individual/\$20,000 family out-of-pocket maximum.
<i>Prescription Drug:</i> \$20/\$30/\$50 copay plan with \$1,500 annual Rx benefit limit
and \$100 deductible for brand Rx. |

One High Deductible Health Plan – H S A Compatible

- | | |
|--|--|
| <input type="checkbox"/> HDHP
PPO Plan Option 11
80/60 | <i>In-Network care:</i> Routine Physicals paid at 100%. Not subject to the deductible.
\$2,500 individual/\$5,000 family deductible. Plan pays 80%.
\$3,500 individual/\$7,000 family out-of-pocket maximum.
<i>Out-of-Network care:</i> \$3,000 individual/\$6,000 family deductible. Plan pays 60%.
\$4,500 individual/\$9,000 family out-of-pocket maximum (includes deductible).
<i>Prescription Drug:</i> \$15/\$25/\$40 in-network. Plan pays 60% after deductible out-of-
network. Prescriptions from non-participating pharmacies subject to deductible. |
|--|--|



Member's Name	Policyholder Number 809359	Member's Social Security Number
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Member's Address

1. Only the Names of Individual(s) Requesting Coverage at this Time Should be Listed.
 Check here if additional dependent children are listed on a separate attachment. (Be sure to include their gender, birth date, height and weight.)

	Name	Is this dependent child age 25 or younger?	Gender	Birth date (MM/DD/YYYY)	Height (ft., in.)	Weight (lb)
Member		N/A	<input type="checkbox"/> M <input type="checkbox"/> F			
Spouse		N/A	<input type="checkbox"/> M <input type="checkbox"/> F			
Dependent Child		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F			
Dependent Child		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F			
Dependent Child		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F			

2. Statement of Health for Individual(s) Listed Above. Give complete dates and details for all "Yes" answers and/or medical impairments checked using the space provided after Question 16.

<input type="checkbox"/>	<input type="checkbox"/>	1. Is diagnostic testing or an operation recommended or contemplated for anyone?																								
<input type="checkbox"/>	<input type="checkbox"/>	2. Is anyone pregnant? If so, provide due date and if there have been any complications thus far or if multiple births are expected.																								
<input type="checkbox"/>	<input type="checkbox"/>	3. Is anyone taking any medication or receiving any treatment or counseling? If "Yes", list individual(s), all medications and dosages, and indicate the underlying condition and/or type of treatment/counseling of being received.																								
<input type="checkbox"/>	<input type="checkbox"/>	4. Has any individual used tobacco products in the last 12 months (cigarettes, cigar, pipe, chewing tobacco)? If Yes Who: _____																								
Have any individuals within the past 10 years:																										
<input type="checkbox"/>	<input type="checkbox"/>	5. Been diagnosed with or treated for chest pain, blood pressure, heart attack, or other diseases of the heart or blood vessels (circulatory system)?																								
<input type="checkbox"/>	<input type="checkbox"/>	6. Been treated for mental, emotional or nervous disorder or depression?																								
<input type="checkbox"/>	<input type="checkbox"/>	7. Been treated for cancer, tumor or other malignancy?																								
<input type="checkbox"/>	<input type="checkbox"/>	8. Been treated for stroke, TIA (mini-stroke) or paralysis?																								
<input type="checkbox"/>	<input type="checkbox"/>	9. Been treated for emphysema, other respiratory or lung diseases or breathing conditions?																								
<input type="checkbox"/>	<input type="checkbox"/>	10. Been treated for diseases of the kidney, pancreas or liver?																								
<input type="checkbox"/>	<input type="checkbox"/>	11. Been treated for or diagnosed as having immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus ("HIV") or other immune system disorders?																								
<input type="checkbox"/>	<input type="checkbox"/>	12. Been diagnosed with diabetes? If "Yes", give date of diagnosis and whether insulin or non-insulin dependent. Please include dosage of insulin and any related problems.																								
<input type="checkbox"/>	<input type="checkbox"/>	13. Been treated for arthritis? If "Yes", specify type, extent of disability and treatment received.																								
<input type="checkbox"/>	<input type="checkbox"/>	14. Been confined in a hospital, clinic, sanitarium or other medical facility?																								
<input type="checkbox"/>	<input type="checkbox"/>	15. Had any disease or impairment of or treatment for any of the following? If "Yes", check the appropriate box(es) below and explain using the space provided.																								
<table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Alcohol Abuse</td> <td><input type="checkbox"/> Drug Abuse</td> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/> Sexually Transmitted Disease</td> </tr> <tr> <td><input type="checkbox"/> Back/Neck/Spine</td> <td><input type="checkbox"/> Ears/Eyes</td> <td><input type="checkbox"/> Lupus</td> <td><input type="checkbox"/> Skin</td> </tr> <tr> <td><input type="checkbox"/> Blood</td> <td><input type="checkbox"/> Epilepsy/Seizures</td> <td><input type="checkbox"/> Migraines</td> <td><input type="checkbox"/> Stomach</td> </tr> <tr> <td><input type="checkbox"/> Bone/Joint</td> <td><input type="checkbox"/> Heart</td> <td><input type="checkbox"/> Muscular Disorder</td> <td><input type="checkbox"/> Thyroid or Gland</td> </tr> <tr> <td><input type="checkbox"/> Brain</td> <td><input type="checkbox"/> Infertility</td> <td><input type="checkbox"/> Neurological</td> <td><input type="checkbox"/> Urinary</td> </tr> <tr> <td><input type="checkbox"/> Congenital Defect</td> <td><input type="checkbox"/> Intestines</td> <td><input type="checkbox"/> Prosthetic Device or Implants</td> <td><input type="checkbox"/> Other _____</td> </tr> </table>			<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Lungs	<input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> Back/Neck/Spine	<input type="checkbox"/> Ears/Eyes	<input type="checkbox"/> Lupus	<input type="checkbox"/> Skin	<input type="checkbox"/> Blood	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Migraines	<input type="checkbox"/> Stomach	<input type="checkbox"/> Bone/Joint	<input type="checkbox"/> Heart	<input type="checkbox"/> Muscular Disorder	<input type="checkbox"/> Thyroid or Gland	<input type="checkbox"/> Brain	<input type="checkbox"/> Infertility	<input type="checkbox"/> Neurological	<input type="checkbox"/> Urinary	<input type="checkbox"/> Congenital Defect	<input type="checkbox"/> Intestines	<input type="checkbox"/> Prosthetic Device or Implants	<input type="checkbox"/> Other _____
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<input type="checkbox"/>	<input type="checkbox"/>	16. Does anyone have any known physical impairment or ill health not mentioned above? If "Yes", give complete details below.																								

3. Provide details to all Yes answers checked above. Indicate here if additional information is on a separate attachment.

Name of Person	Question Number	Illness/Condition/Treatment/Medication	Began Month/Year	Time Lost From Normal Activities	Full Recovery Month/Year

Certification. I declare that to the best of knowledge and belief, the above statements are complete and true. I will inform Aetna of any material changes to the information provided which take place between the time the form is completed and the time coverage becomes effective. I agree that (1) the insurance applied for is subject to the policy terms and shall become effective on the date or dates established by the policy, provided the evidence of insurability is satisfactory, (2) this form supersedes any prior form I may have completed with respect to the insurance being applied for.

In order to be eligible for and maintain the insurance indicated above (a) I am a member of the State Bar of Texas (b) I must continue such membership to keep this insurance in force, (c) I must be working on a full time basis on the effective date of coverage, (d) I hereby request participation in the State Bar of Texas Insurance Trust and agree to be bound by its terms, and (e) I will remit required contributions for such insurance when due.

Misrepresentation. Any Person who knowingly and with intent to injure, defraud or deceive 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 of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal or civil penalties.

Authorization For the Release of information. I authorize any physician, other healthcare professional, hospital, and any other healthcare institution to disclose, at any time and to the extent allowed by law, to Aetna Life Insurance Company or an affiliated entity ("Aetna"), information concerning healthcare advise, treatment or supplies provided to my spouse or dependents or to myself, including those involving mental health, substance abuse and HIV/AIDS ("healthcare information"). In addition, I also authorize Aetna to redisclose the healthcare information to healthcare professionals and institutions; independent claims administrators, utilization review organizations and reinsurers with which Aetna has contracted. This authorization is valid until two years after the effective date of any coverage issued in connection with it.

Acknowledgment: Applicant acknowledges that Aetna Life Insurance Company's participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of Aetna Life Insurance Company.

Signature of Member: _____ Date: _____ Signature of Spouse: _____ Date: _____