

Aetna Affordable Health Choices®

Member Reference Guide Option II

Facts about the plan

Group name:AmeriCorps

Eligible members:All active full-time members of an AmeriCorps Program, provided the member is not covered by another health care plan (other than Medicaid or Medicare).

Eligibility:Immediate.

Your coverage begins:Immediately, provided you are eligible.

Plan name:Aetna Affordable Health Choices®

Underwriter of the coverage(s) issued under the plan:

Insurance plans:.....Aetna Life Insurance Company
151 Farmington Avenue
Hartford, Connecticut 06156

Aetna affiliate:.....Strategic Resource Company (SRC)
221 Dawson Road / PO Box 23759
Columbia, SC 29224-3759

Insured members: Benefits/Enrollment:1-800-788-6557
Claims inquiries:1-800-788-6557

Providers: General:1-800-788-6557
Verification of Benefits:.....1-888-772-9682

Provider(s) of the discount program(s) within the plan:

Eyewear Discount Program:.....Aetna VisionSM Discounts
Exam and Eyewear:1-800-793-8616 (Weekdays 9 a.m. - 9 p.m., Saturday 9 a.m. - 5 p.m. ET)
LASIK Customer Service:1-800-422-6600 (Weekdays 8 a.m. - 9 p.m., Saturday 9 a.m. - 6 p.m. ET)
Contacts DirectTM:1-800-391-5367www.aetna.com/docfind/custom/aahc

Extra-Territorial Information

Some states require that certain benefits or provisions be provided to their residents regardless of where the group insurance policy that covers those residents is issued. If you are a resident of one of those states, your state's requirements will apply to you in place of the benefits or provisions in your policy when those requirements provide a greater benefit or right than described in your policy.

Filing a Claim

How do I file a claim? Obtain a claim form for the type of claim you are filing by:

- Calling Claims Customer Service at **1-800-788-6557** Monday through Friday, 8:00 a.m. to 8:00 p.m. ET
- Writing to Strategic Resource Company, Attn: AmeriCorps Claims, PO Box 23907, Columbia, SC 29224-3907.
- Contacting the AmeriCorps Program Director.

These claim forms contain instructions on how to fill them out (some forms include sections for your program to fill out). If a member dies as the result of an accident, their beneficiary should apply for the insurance benefit as soon as possible.

Send completed forms to Strategic Resource Company, Attn: AmeriCorps Claims, PO Box 23907, Columbia, SC 29224-3907. Your doctor or dentist may prefer to file a claim for you using his or her own form. But if you have a claim, you must send in a signed claim form of the type utilized by this plan. This will help ensure prompt processing of your claim. If you have medical expenses resulting from an accident, you must provide full details of the accident on your completed claim form. The insurer reserves the right to require a medical examination at its expense. For Customer Service call **1-800-788-6557**, Monday through Friday, 8:00 a.m. to 8:00 p.m. ET.

What if I have a Certificate of Creditable Health Coverage from a former employer? If you submit it and it is approved, your pre-existing Waiting Period can be reduced, even eliminated. Make a copy of your certificate and send it to the claims address shown above. If you have lost your certificate, you may request another from the former employer.

How do I (or a beneficiary) appeal a denied claim? If all or a part of your claim is denied, you or the member's beneficiary will be provided a written explanation by the insurance company which will include:

- The specific reasons for the denial;
- Reference to the pertinent plan provisions upon which the denial is based;
- A description of any additional information you might be required to provide and explanation of why it is needed; and
- An explanation of the plan's claim review procedure.

You, your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to the insurance company. In connection with such a request, documents pertinent to the administration of the plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure. A request for a review must be filed by 180 days after receipt of the written notice of denial of a claim. The full and fair review will be held and a decision rendered by the insurance company no longer than 60 days (45 days for term life or short term disability claims, if included in your plan) after receipt of the request for the review.

In the case of a claim involving urgent care, you will be notified of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request of an adverse benefit determination by the plan. A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: (a) could seriously jeopardize the life or health of the claimant to regain maximum function, or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If there are special circumstances, the decision will be made as soon as possible, but not later than 120 days (90 days for term life or short term disability claims, if included in your plan) after receipt of the request for the review. If such an extension of time is needed, you will be notified in writing prior to the beginning of the time extension period. The decision after your review will be in writing and will include specific reasons for the decision as well as specific references to the pertinent plan provisions on which the decision is based.

**Health Insurance Plans are underwritten
by Aetna Life Insurance Company (Aetna).**

Plans are administered by
Strategic Resource Company (SRC).

MRG: V-001 ED-001 AMERICORPS (08/06)





AmeriCorps Medical Benefits – Claim Instructions

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 and civil penalties.

Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention California, Ohio and Pennsylvania Residents: 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 of 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.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention North Carolina Residents: 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 may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: 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 act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM. FOR FASTER, EASIER SUBMISSION OF CLAIMS, THE PROVIDER MAY CONTACT THE AETNA CLAIM PROCESSING CENTER FOR INFORMATION REGARDING ELECTRONIC CLAIM SUBMISSIONS.

TO THE MEMBER

1. Complete blocks 1-16 in full.
2. Complete blocks 17-18 only if other medical coverage exists.
3. Be certain to sign the authorization to release information block (19).
4. If you wish to have your benefits for this claim paid directly to your physician or supplier, sign block (20).
5. If you have submitted a request for benefits to another plan, including Medicare, attach a copy of the bills you submitted to the other plan and the explanation of benefits you received from the other plan.
6. Attach itemized bills or ask your health care provider to complete the applicable section on the reverse side. The bills must include:

- patient's name
- date(s) of service(s)
- condition being treated
- relationship to member
- type of service(s) rendered

If this information is missing, write it on the bill and sign your name.

7. If prescription drugs are covered under your plan, submit receipts or a Prescription Drug Record form. Receipt must contain:
 - drug name
 - dose per/day
 - charge
 - purchase date
 - nature of illness or injury
 - strength
 - prescription number
 - quantity
 - physician's name
 - pharmacy name/address

This information can be copied from the prescription bottle or box.

8. Retain copies of your bills for your record.
9. Send the completed benefits request and the bills to: **SRC, an Aetna Company**
Attn: Claim Department
P.O. Box 23907
Columbia, SC 29224-3907
Fax to: 1-803-333-1402
Phone: 1-888-772-9682

TO THE PHYSICIAN OR SUPPLIER

1. Complete items 21-40 in full.
2. If the employee indicates that benefits should be paid directly to the physician or supplier, then these benefits will be sent directly to you with an information copy of the transactions to the member.



AmeriCorps Medical Benefits Request

Mail to: **SRC, an Aetna Company**
Attn: Claim Department
P.O. Box 23907
Columbia, SC 29224-3907
Fax to: 1-803-333-1402
Phone: 1-888-772-9682

TO BE COMPLETED BY MEMBER			
1. AmeriCorps Program Name		2. Policy/Group Number	
3. Member's Aetna ID Number	4. Member's Name		5. Member's Birthdate (MM/DD/YYYY)
6. Member's Address (include zip code) <input type="checkbox"/> Address is new			7. Member's Daytime Telephone Number ()
8. Patient's Name	9. Patient's Aetna ID Number	10. Patient's Birthdate (MM/DD/YYYY)	11. Patient's Relationship to Member <input type="checkbox"/> Self <input type="checkbox"/> Child
12. Patient's Address (if different from member)		13. Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	14. Patient's Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single
15. Is claim related to an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date _____ time _____ <input type="checkbox"/> am <input type="checkbox"/> pm			16. Is claim related to AmeriCorps duties? <input type="checkbox"/> No <input type="checkbox"/> Yes
17. Are your expenses covered by another group health plan, group pre-payment plan (Blue Cross- Blue Shield, etc.), no fault auto insurance, Medicare or any federal, state or local government plan? <input type="checkbox"/> No <input type="checkbox"/> Yes		18. If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator.	
19. To all providers of health care: You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original. Patient's or Authorized Person's Signature _____ Date _____			
20. I authorize payment of medical benefits to the physician or supplier of service. Patient's or Authorized Person's Signature _____ Date _____			

TO BE COMPLETED BY PHYSICIAN OR SUPPLIER			
21. Date of illness (first symptom) or injury (accident) or pregnancy (LMP)	22. Date first consulted you for this condition	23. If patient has had similar illness or injury, give dates	24. If an emergency check here <input type="checkbox"/> emergency
25. Date patient able to return to work	26. Date of total disability from _____ through _____		27. Date of partial disability from _____ through _____
28. Name of referring physician (e.g., Public Health Agency)		29. For services related to hospitalization give hospitalization dates admitted _____ discharged _____	
30. Name & address of facility where services rendered (if other than home or office)			
31. Diagnosis or nature of illness or injury (please indicate primary and secondary)			
1.			
2.			
3.			
4.			

32. Procedures, Medical Services, Supplies Furnished								
Date of Service	Place of Service*	Procedure Code Identify**	Description of Service	Type of Service †	Charges	Days or Units	Diagnosis Code ††	Administrative Use Only
33. Physician's Name & Address (include zip code)				34. Telephone Number ()		35. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.		
38. Physician's or Supplier's signature				36. Patient Account Number		37. Total charge \$ _____ Amount paid \$ _____ Balance due \$ _____		
39. National Provider Identifier				40. Date				

* Place of Service Codes:
1 - (IH) - Inpatient Hospital
2 - (OH) - Outpatient Hospital
3 - (O) - Office Visit
4 - (H) - Patient Home
5 - - Day Care Facility (PSY)
6 - - Night Care Facility (PSY)
7 - (NH) - Nursing Home

8 - (SNF) - Skilled Nursing Facility
9 - - Ambulance
0 - (OL) - Other Location
A - (IL) - Independent Laboratory
B - - Other Medical Surgical Facility
C - (RTC) - Residential Treatment Center
D - (STF) - Specialized Treatment Facility

† Type of Service Codes:
1 - Medical Care
2 - Surgery
3 - Consultation
4 - Diagnostic X-Ray
5 - Diagnostic Laboratory
6 - Radiation Therapy
7 - Anesthesia

8 - Assistance at Surgery
9 - Other Medical Service
0 - Blood or Packed Red Cells
A - Used DME
M - Alternate Payment for Maintenance Dialysis
Y - Second Opinion on Elective Surgery
Z - Third Opinion on Elective Surgery

** Please Use Current Procedural Terminology Codes For Surgery
†† Please Use ICD-9-CM For Discharge Diagnosis



AmeriCorps Dental Benefits – Claim Instructions

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Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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Attention North Carolina Residents: 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 may be a crime and subjects such person to criminal and civil penalties.

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Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: 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 may be a crime and may subject such person to criminal and civil penalties.

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Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM. FOR FASTER, EASIER SUBMISSION OF CLAIMS, THE PROVIDER MAY CONTACT THE AETNA CLAIM PROCESSING CENTER FOR INFORMATION REGARDING ELECTRONIC CLAIM SUBMISSIONS.

TO THE MEMBER

1. Complete blocks 1–16 in full.
2. Complete blocks 17–18 only if other dental coverage exists.
3. Be certain to sign the authorization to release information block 19.
4. If you wish to have your benefits for this claim paid directly to your dentist, sign block 20.

If total charges for the planned course of treatment are expected to exceed the minimum Predetermination dollar amount stated in your dental plan booklet, it is suggested you file for Predetermination of Benefits. Aetna Dental will notify your dentist of the benefits payable.

NOTE: YOUR DENTAL COVERAGE IS SUBJECT TO SPECIFIC LIMITATIONS AND EXCLUSIONS. PLEASE REFER TO YOUR DENTAL BOOKLET FOR DESCRIPTION OF COVERED EXPENSES, DEDUCTIBLE AND COPAYMENT INFORMATION, AND LIMITATIONS AND

EXCLUSIONS.

TO THE DENTIST

1. **COMPLETED SERVICES** — Check the box noted "STATEMENT OF SERVICES RENDERED" and complete blocks 21-39. When entering the treatment plan on the form, please indicate a separate fee for each individual service rendered.
2. **PREDETERMINATION OF BENEFITS** — If total charges for this claim are to exceed the minimum Predetermination dollar amount indicated in the member's Dental Plan Booklet (and treatment is not emergency in nature), Predetermination of Benefits is suggested. Check the box marked "PRE-TREATMENT ESTIMATE", and complete blocks 21-39.

NOTE: PREDETERMINATION OF BENEFITS IS ONLY INTENDED TO AVOID MISUNDERSTANDINGS BETWEEN THE MEMBER, DENTIST AND INSURANCE COMPANY CONCERNING BENEFITS PAYABLE. YOU AND YOUR PATIENT ARE, OF COURSE, FREE TO PURSUE ANY TREATMENT PLAN YOU THINK BEST.

3. If the employee indicates that benefits should be paid directly to the dentist, these benefits will be sent directly to you with a copy of the transaction to the member.

***X-rays taken for metal restorations and crowns should be submitted with treatment plan. They may also be requested for other services. X-rays will be reviewed by practicing Dentists and returned promptly.**

TO THE EMPLOYEE & DENTIST

Send the completed benefits request and the bills to: **SRC, an Aetna Company
Attn: Claim Department
P.O. Box 23907
Columbia, SC 29224-3907
Fax to: 1-803-333-1402
Phone: 1-888-772-9682**



AmeriCorps Dental Benefits Request

Mail to: SRC, an Aetna Company
 Attn: Claim Department
 P.O. Box 23907
 Columbia, SC 29224-3907
 Fax to: 1-803-333-1402
 Phone: 1-888-772-9682

TO BE COMPLETED BY MEMBER

1. AmeriCorps Program Name		2. Policy/Group Number	
3. Member's Aetna ID Number	4. Member's Name		5. Member's Birthdate (MM/DD/YYYY)
6. Member's Address (include zip code) <input type="checkbox"/> Address is new			7. Member's Daytime Telephone Number ()
8. Patient's Name	9. Patient's Aetna ID Number	10. Patient's Birthdate (MM/DD/YYYY)	11. Patient's Relationship to Member <input type="checkbox"/> Self <input type="checkbox"/> Child
12. Patient's Address (if different from member)		13. Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	14. Patient's Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single
15. Is claim related to an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date _____ time _____ <input type="checkbox"/> am <input type="checkbox"/> pm			16. Is claim related to AmeriCorps duties? <input type="checkbox"/> No <input type="checkbox"/> Yes
17. Are your expenses covered by another group health plan, group pre-payment plan (Blue Cross- Blue Shield, etc.), no fault auto insurance, Medicare or any federal, state or local government plan? <input type="checkbox"/> No <input type="checkbox"/> Yes		18. If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator:	
19. To all providers of dental care: You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting dental professionals and utilization review organizations with whom Aetna has contracted, information concerning dental care, advice, treatment or supplies provided the patient. This information will be used to evaluate claims for dental benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original. Patient's or Authorized Person's Signature _____ Date _____			
20. I authorize payment of dental benefits to the dentist or supplier of service. Patient's or Authorized Person's Signature _____ Date _____			

TO BE COMPLETED BY DENTIST

21. This is a request for: <input type="checkbox"/> Request for Pre-Treatment Estimate Predetermination/Preauthorization Number _____ <input type="checkbox"/> Statement of Services Rendered							
22. Dentist's Name & Address (include zip code)		23. National Provider Identifier	24. Dentist License No.	25. Telephone Number ()			
26. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.							
27. First Visit Date Current Series		28. Place of Treatment <input type="checkbox"/> Office <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other		29. Radiographs or models enclosed? <input type="checkbox"/> No <input type="checkbox"/> Yes How many?			
Is treatment result of:		No	Yes	If yes, enter brief description and dates			
30. occupational illness or injury?							
31. auto accident?							
32. other accident?							
33. Are any services covered by another plan?							
34. If prosthesis, is this initial placement?		If no, date of prior placement and reason for replacement					
35. Is treatment for orthodontics?		Date appliance placed: _____		Initial Appliance Fee: _____			
		No. of months of treatment: _____		Monthly Fee: _____			
		Mos. of treatment remaining: _____		Total Case Fee: _____			
36. To expedite claim handling, identify all missing teeth with "X"		37. Examination and treatment plan. List in order from tooth no. 1 through tooth no. 32. Use charting system shown.					
	Tooth # or Letter	If Previously Extracted, Give Date	Surface	Description of Service (x-rays, prophylaxis, materials used, etc.)	Date Service Performed MM DD YYYY	Procedure Number	Fee
38. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged this patient and intend to accept for those procedures. Dentist's Signature _____ Date _____				39. National Provider Identification		Total charge \$ _____ Amount paid \$ _____ Balance due \$ _____	



AmeriCorps Proof of Death

Group Life Insurance and Group Accidental Death Benefit Request

(Filing instructions on reverse side)

Mail this completed form to:
 SRC, an Aetna Company
 Attn: Claim Department
 Post Office Box 23907
 Columbia, SC 29224-3907
 Fax to: 1-803-333-1402
 Phone: 1-888-772-9682

A. Information About the Deceased Member

Deceased Member's Name (last, first, middle initial)		If deceased is known by any other name, provide Name (last, first, middle initial)			
Relationship to Member	Social Security Number	Birthdate (MM/DD/YYYY)	Date of Death (MM/DD/YYYY)	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Last Residence: Street		City		State	Zip
Date active with AmeriCorps program (MM/DD/YYYY)	Member's Work Location Name or Number		Last active date with AmeriCorps program (MM/DD/YYYY)		
Reason member did not return after last active date with AmeriCorps program					

B. Information About the Member's Coverage

AmeriCorps Program Name		Representative's / Contact's Name / Email Address			
Street Address		City	State	Zip	
Telephone Number		Fax Number			
Coverages for which benefits are in effect					
<input type="checkbox"/> Group Coverage	AmeriCorps Group Number	Plan	Effective date of member's insurance (MM/DD/YYYY)	Amount of insurance in force as of the last active day with AmeriCorps program	
<input type="checkbox"/> Group Accidental Death		II	/ /		
<input type="checkbox"/>			/ /		
Were premiums paid through the date of death for this member? <input type="checkbox"/> No <input type="checkbox"/> Yes			If insurance is not in effect give date discontinued (MM/DD/YYYY)		

C. Information About The Beneficiary(ies)

	1.	2.	3.
Name			
Street			
City			
State/Zip			
Social Security Number			
Relationship to Member			
Birthdate (MM/DD/YYYY)			
Telephone number			
Home			
Work			
Has benefit/ownership been assigned? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, to whom? (send copy of assignment)		Assignee's Social Security Number

D. Benefit Distribution Instructions

Return the benefit payment directly to:
 Beneficiary AmeriCorps Program (Checkbook to Beneficiary Only) Other _____

E. AmeriCorps Program's Instructions

- Please mail or fax the Life Insurance claim to our office (address and fax number listed above). If faxing the Life Insurance claim, it is not necessary to follow-up with the original documents. Complete the deceased name on the top of Page 2 before faxing.
 - The insured's death certificate*.
 - Original beneficiary designation and any or all change of beneficiary requests.
 - Roster forms (current and prior two years).
 - If beneficiary(ies) are minor children:
 - a) Their birth certificates & Social Security numbers*
 - b) Letters of Guardianship* or conservatorship of the estate of the minor child*
 - If beneficiary is the insured's estate:
 - a) The Letters of Administration or Letters of Testamentary.*
 - If beneficiary is a trust:
 - a) Provide copies of trust and letter of acceptance from trustee with Trust ID number.
 - If designated beneficiary predeceased the member:
 - a) A copy of the beneficiary's death certificate
 - b) Aetna Affidavit of Sole Survivors completed by a family representative.
 - If Accidental Death benefits are being claimed, submit police/accident, autopsy and toxicology reports with any available newspaper articles concerning the accident, if the reports are available.*
- Complete the deceased name on the top of Page 2 before the Life insurance claim is faxed to our office at 1-803-333-1402. It is not necessary to follow-up with the original documents.

If you have any additional questions on the submission of this claim, please contact our office at 1-888-772-9682.
 * This information should be supplied by the beneficiary or the beneficiary's representative.

Deceased Information

Name (last, first, middle initial)
Social Security Number

F. AmeriCorps Program's Authorized Representative

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 and civil penalties.

Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention California, Ohio and Pennsylvania Residents: 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 of 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.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties

Attention New York Residents: 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 of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: 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 may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: 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 act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Name _____ Signature _____

Date (MM/DD/YYYY) _____ at (city, state, zip) _____



Aetna Affidavit of Sole Survivors

Mail to: SRC, an Aetna Company
 Attn: Claim Department
 Post Office Box 23907
 Columbia, SC 29224-3907
 Fax to: 1-803-333-1402
 Phone: 1-888-772-9682

Instructions: This form is for informational purposes only and completion does not constitute a claim for any type of benefits. Please provide information only for those next of kin who survive and those who died AFTER the death of the insured.

***** Please use the reverse side of this form for additional children/siblings and indicate the relationship*****

Print or Type Information

Name of Deceased	Decease's Social Security Number	Date of Death	Policy Number
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Next of Kin	Print First Name and Last Name	Date of Birth	Date of Death	Social Security Number	Street Address	City	State	Zip Code
Husband or Wife								
All Children (Natural or legally adopted. No Step-children)								
Parents (Natural or Adoptive parents)	Father:							
	Mother:							
All Brothers & Sisters (Natural or legally adopted. No Step-siblings)								

<i>If none of the above survive, provide member's estate representative information</i>	Name of Estate Representative	Address (street, city, state, zip code)	Telephone Number

Informant Information – Please Print

Informant Name	Informant Address	Informant Telephone Number
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SEAL REQUIRED

I affirm, under penalty of false statement, that the information provided is true and complete to the best of knowledge and belief.

Informant Signature: _____

Subscribed and sworn to before me, this ____ day of _____, 20__ in the State of _____

 Notary Public Signature

Commission Expires: _____

