

# SONNY A. HENNING INSURANCE

9671 CASTLE WOODS COVE, INDIANAPOLIS, IN 46280 FAX 888-766-8288  
TOLL FREE 1-888-SONNY-32 (888-766-6932)

Thank you for your interest in our Health Plans. I have attached a more detailed description for the quoted program.

Please print the attached file and complete all application forms per the instructions. Paperwork and checks must be returned to:

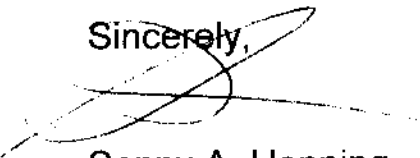
**SONNY A. HENNING  
SONNY HENNING INSURANCE  
9671 CASTLE WOODS COVE  
INDIANAPOLIS, IN 46280**

Please include a check, payable to the name instructed on the attached and be sure to include any requested tax documentation. **In addition, please include a check, payable to Sonny Henning Insurance in the amount of \$50.00 as a one time processing and handling fee.**

All forms must be received by the 15<sup>th</sup> of the month for a 1st of the month effective date.

If you have any questions, please feel free to call, toll free, at your convenience **1-888-SONNY-32 (1-888-766-6932)**.

Sincerely,



Sonny A. Henning  
SAH:ms  
Attachments

**BE SURE TO REMEMBER US FOR ALL YOUR LIFE AND  
HEALTH INSURANCE NEEDS, INCLUDING LIFE, HEALTH,  
DISABILITY, LONG TERM CARE AND OTHER SENIOR  
PRODUCTS.**

## **HOW TO GET STARTED?**

JUST FOLLOW THE SIMPLE INSTRUCTION BELOW AND MAIL  
ALL PAPERWORK AND CHECKS TO :

SONNY HENNING INSURANCE  
9671 CASTLE WOODS COVE  
INDIANAPOLIS, IN 46280

**AETNA - POS**  
**FLEX LIBERTY PLAN**  
**NY&NJ**

**WWW.AETNA.COM**

- COMPLETE ATLANTIC BUSINESS ASSOCIATION FORM
- COMPLETE ATLANTIC BUSINESS ASSOCIATION AFFILIATION AGREEMENT FORM
- COMPLETE AETNA ENROLLMENT FORM

**INLCUDE ONE CHECK FOR THE FIRST MONTH'S PREMIUM  
PLUS THE ANNUAL ADMINISTRATION FEE OF \$40,  
PAYABLE TO INTERNATIONAL BENEFIT ADMINSTRATORS**

**PLUS**

**A ONE TIME PROCESSING FEE OF \$50.00, PYABALE TO  
SONNY HENNING INSURANCE.**

**AETNA - POS  
LIBERTY FLEX PLAN  
NEW YORK AND NEW JERSEY**

**Rates effective 4/1/03 through 04/1/04**

<b>SINGLE:</b>	<b>\$ 543.00</b>
<b>TWO PARTY</b>	<b>\$ 787.00</b>
<b>FAMILY:</b>	<b>\$1,055.00</b>

**Plus \$40 Annual Administration Fee**

**TAKE A LOOK AT THESE BENEFITS:**

**IN NETWORK**

**\$20 - OFFICE COPAY  
\$250 HOSPITAL COPAY  
RX - \$10/\$20/\$50 COPAY**

**OUT OF NETWORK**

**\$1,000/\$2,000 DEDUCTIBLE  
70/30 CO-INSURANCE  
\$4,000/\$8,000 MAXIMUM OUT OF POCKET**

**WWW.AETNA.COM**

**ABA**  
Atlantic Business Association

**EMPLOYEE INFORMATION**

**First Name** \_\_\_\_\_ **Last Name** \_\_\_\_\_

**Address** \_\_\_\_\_  
\_\_\_\_\_

**Phone Number** \_\_\_\_\_

**Social Security #** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**EMPLOYER INFORMATION**

**Name** \_\_\_\_\_

**Address** \_\_\_\_\_  
\_\_\_\_\_

**Phone Number** \_\_\_\_\_

**Date of Hire** \_\_\_\_\_

**Signature** **X** \_\_\_\_\_

**ATLANTIC BUSINESS ASSOCIATION AFFILIATION AGREEMENT**

**ATLANTIC BUSINESS ASSOCIATION, INC (ABA) HAS ENTERED INTO AN AGREEMENT ON JANUARY 1, 2004 WITH UAW LOCAL 2326 AFLCIO.**

**AS A MEMBER OF ABA, THE MEMBER UNDERSTANDS THAT IT IS BOUND BY THE AGREEMENT IN EFFECT BETWEEN ABA AND THE UNION. REMITTANCES MADE BY THE MEMBER TO ABA, INC. AS FOLLOWS: BENEFIT PLAN CONTRIBUTIONS, UNION DUES AND ADMINISTRATIVE AND BILLING FEES.**

**THE MEMBER UNDERTAKES TO INDEMNIFY ABA, INC. FROM ANY AND ALL LIABILITY THAT MIGHT RESULT FROM THE ABOVE SAID AGREEMENT.**

**ABA, INC. / UNION AGREEMENT IS ON FILE AT THE OFFICE OF ABA, INC. LOCATED AT:**

**TWO EXECUTIVE DRIVE  
FORT LEE, NJ 07024**

**BY: \_\_\_\_\_**

**MEMBER**

**BY: \_\_\_\_\_**

**DATE: \_\_\_\_\_**



# New Jersey Small Group Enrollment/Change Request

## Aetna Health Inc.

Employer Group Information - To Be Completed by Employer

Group Name: \_\_\_\_\_ Account: \_\_\_\_\_ Plan No.: \_\_\_\_\_  
 Medical - Control: \_\_\_\_\_ Suffix: \_\_\_\_\_  
 Dental - Control: \_\_\_\_\_ Suffix: \_\_\_\_\_ Plan No.: \_\_\_\_\_

### A. Type of Activity - To Be Completed by Employer Refer to instructions on back before completing this form. Print clearly.

**1. Enrollment**  
 New Enrollee Subscriber  
 Effective Date: \_\_\_\_\_  
 Date of Hire: \_\_\_\_\_

**2. Change - Check all that apply. Date of Event: \_\_\_\_\_ Reason: \_\_\_\_\_**  
 Add Spouse  
 Add Dependent Child  
 Name Change  
 Change Plan  
 Other  
 Add Change Office ID Numbers: Primary: \_\_\_\_\_ Dentist: \_\_\_\_\_

**3. Remove or Terminate - Check all that apply. Effective Date: \_\_\_\_\_ Reason: \_\_\_\_\_**  
 Remove Spouse\*  
 Remove Dependent Child\*  
 Employee Withdrawal Termination  
 \* NOTE: Employee must be enrolled for spouse dependent(s) to have coverage.  
 \* Please complete *Add/Change/Remove* and *Notice* columns in Section D.

### B. Employee Information - Complete Sections B - H.

Last Name, First Name, M.I.: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Telephone: \_\_\_\_\_  
 Employer Name: \_\_\_\_\_  
 Work Address: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Work Telephone: \_\_\_\_\_

### C. Plan Option - Your selection must be offered by your employer.

Medical - Check One:  
 Aetna Primary Care™ Plan HMO  
 Aetna Choice™ Plan POS  
 Aetna Primary Care™ Plan HMO (with No Referrals)  
 Aetna Choice™ Plan POS (with No Referrals)  
 Mandated Plan Option (HMO \$15 Copay Option)  
 Primary Copay (Check One):  \$10  \$15  \$20  \$30

Dental - Check One:  
 Value HMO Rider  
 Standard:  DMO or  PPO  
 Premier:  DMO or  PPO

### D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach proof if full-time college student.

Individuals Covered	Last Name, First Name, M.I.	Sex	Birthdate	Social Security Number	Health Coverage	Other Health Coverage	Primary Office ID Number	Current ID Number (if applicable)	Dentist Office ID Number	Current Permit	Permit
Employee		<input type="checkbox"/> M <input type="checkbox"/> F	MM / DD / YYYY		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Spouse		<input type="checkbox"/> M <input type="checkbox"/> F	MM / DD / YYYY		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Child		<input type="checkbox"/> M <input type="checkbox"/> F	MM / DD / YYYY		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Child		<input type="checkbox"/> M <input type="checkbox"/> F	MM / DD / YYYY		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Child		<input type="checkbox"/> M <input type="checkbox"/> F	MM / DD / YYYY		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No					

### E. Pre-Existing Conditions Statement

NOTE: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be covered under a health benefit plan on the basis of pre-existing conditions in the following questions. Carriers can only use the information to exclude the processing of claims.

1. During the past 6 months, have you or any dependent covered had or been diagnosed as having any of the following? If "Yes," check appropriate box(es) below.

a. Alcoholism or Drug Abuse  
 b. Anemia  
 c. Bicuspid Aortic Valve  
 d. Back or Neck Disorder, Injury or Pain  
 e. Cancer: Lunges  
 f. Diabetes  
 g. Glaucoma or Retinal Disorder  
 h. Heart Disorder or Condition or Chest Pain  
 i. High Blood Pressure  
 j. Kidney or Liver Disorder  
 k. Lung or Respiratory Disorder  
 l. Menstrual or Gynecological Disorder  
 m. Paralysis, Stroke or Epilepsy

2. During the past 6 months, have you or any dependent, to be covered, been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above?  
 a. Yes  No  
 b. If "Yes," have you had treatment or surgery or testing that has not been done?  
 c. Yes  No  
 d. If "Yes," have you been admitted to a hospital or other health care facility as an inpatient?  
 e. Yes  No  
 f. If "Yes," have you taken prescribed medications?

### F. Other Insurance

Is your Spouse Employed?  Yes  No If "Yes," give name & address of spouse's employer.  
 If "Yes" to Other Health Coverage (Section D), give name & policy number of insurance carrier HMO or other "so on".  
 Explain the circumstances.  
 If any dependents are named other than yours, explain the circumstances.

### G. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? If "Yes," who and what address?  
 Yes  No  
 Explain the circumstances.  
 If any dependents are named other than yours, explain the circumstances.

### H. Employee Signature

If you have questions concerning the benefits and services provided by or excluded under this Evidence of Coverage, contact a Member Services representative at 1-800-323-9930 before signing this form.  
 I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this application.  
 Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Employee Signature - Required:  Yes  No  
 Date: \_\_\_\_\_

**Employee Verification - To Be Completed by Employer**  
 Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Employee Signature - Required:  Yes  No  
 Date: \_\_\_\_\_

**Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Aetna Health Inc. prior to visiting a specialist or admission to a hospital.**



**AETNA HEALTH INC.® QUALITY POINT-OF-SERVICE™ PROGRAM**  
**FLEX HMO / Liberty Flex Plan**  
**UAW LOCAL 2326 AFL CIO**

	<u><i>NJ Resident</i></u>	<u><i>NJ Non-Resident*</i></u>
<b>FINANCIAL</b>		
Deductible: Single/Family	N/A	\$1,000/\$2,000
Coinsurance	N/A	70%
Coinsurance Limit: Single/Family	N/A	\$4,000/\$8,000
Lifetime Maximum Benefit	N/A	\$1,000,000
<b>PRIMARY CARE PHYSICIAN VISITS</b>		
Office Hours	\$20 copay	70% after deductible
After Hours / Home Visits	\$25 copay	70% after deductible
<b>SPECIALTY CARE</b>		
Office Visits	\$20 copay	70% after deductible
Diagnostic Outpatient Testing	\$20 copay	70% after deductible
Phys, Occ, Speech Therapy	\$20 copay	70% after deductible
<b>SPU SURGERY</b>		
	\$100 copay	70% after deductible
<b>HOSPITALIZATION</b>		
	\$250 copay/A	70% after deductible
<b>SKILLED NURSING FACILITY</b>		
	\$250 copay/A	70% after deductible
<b>EMERGENCY ROOM (copay waived if admitted)</b>		
	\$50 copay	\$50 copay
<b>HOME CARE</b>		
	No copay	70% after deductible
<b>MATERNITY</b>		
First OB Visit	\$20 copay	70% after deductible
Hospital	\$250 copay/A	70% after deductible
<b>MENTAL HEALTH</b>		
Inpatient	\$250 copay/A, 35 days	70% after deductible, 30 days
Outpatient	\$25 copay/V, 20 visits	70% after deductible, 30 visits
<b>SUBSTANCE ABUSE</b>		
Detoxification	\$250 copay/A	70% after deductible, 7 days
Inpatient Rehabilitation	\$250 copay/A, 30 days	70% after deductible, 30 days
Outpatient Rehabilitation	\$20 copay/V	70% after deductible, 30 visits
<b>PREVENTIVE CARE</b>		
Routine Eye Exam (per benefit schedule)	\$20 copay	Not covered
Routine Physicals	\$20 copay	See Insurance Certificate
Immunizations	\$20 copay	See Insurance Certificate
Routine Mammography	\$20 copay	Covered (state-specific guidelines)
Routine GYN Exam	\$20 copay	Not covered
Pediatric Preventive Dental Exam	Not Covered	Not covered
<b>CHIROPRACTIC CARE</b>		
	\$20 copay/V, 20 visits	70% after ded, \$1000/yr (no limit in NY)
<b>PRESCRIPTION LENS REIMBURSEMENT</b>		
	\$100 every 24 months	
<b>PRESCRIPTIONS</b>		
31-90 Day Supply (RETAIL & MOD)	\$10/\$20 G/B, 30 Day \$20/40 G/B copay	
<b>DURABLE MEDICAL EQUIPMENT</b>		
	No copay	70% after deductible
<b>MAX OUT OF POCKET (copay + coinsurance)</b>		
Single/Family	\$1,500/\$3,000	

\* Member precertification required or benefits paid will be substantially reduced.

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To receive maximum benefits, in-network (preferred) services must be provided or referred by the participating primary care physician you selected. In-network (preferred) benefits are provided by Aetna Health Inc.®. Out-of-network (non-referred) benefits are underwritten by Corporate Health Insurance Company®. All benefits, exclusions and limitations are provided in accordance with the applicable group agreement and insurance certificate.