Enrollment/Change Request

Aetna Health Inc.

Employer Group Information - To Be Completed by Employer:	Group Name	Group Number	Class Code

A. Type of Activity - Employee Completes Sections A - E. *Please Print Clearly.*

Instructions: *Refer to the instructions on the back before completing this form. You, the employee, must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.*

Enrollment

☐ New Enrollee/Subscriber

Effective Date / /

Date of Hire / /

Change - *Check all that apply.*

☐ Add Spouse
☐ Add Dependent Child
☐ Name Change
☐ Change Plan
☐ Other

Date of Event / /

Reason

Remove or Terminate - *Check all that apply.*

☐ Remove Spouse
☐ Remove Dependent Child
☐ Employee Withdrawal/ Termination

Effective Date / /

Reason

Continuation of Coverage, i.e., COBRA, State - ***Not all options are available. Contact Employer for available options.***

Coverage For: ☐ Employee ☐ Dependents

Length of Continuation: ☐ 18 ☐ 36 ☐ Other _____

☐ 29 - Attach disability determination from the Social Security Admin.

Date of Loss of Coverage: / /

Date of Qualifying Event: / /

B. Employee Information

Social Security Number	Last Name, First Name, M.I.		Home Telephone ( )
Home Address	Apt. No.	City, State	ZIP Code
Employer Name			Work Telephone ( )
Work Address		City, State	ZIP Code

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

Check One:

☐ HMO ☐ QPOS® ☐ USAccess®

☐ Aetna Open Access™ HMO

☐ Aetna Choice™ POS

Indicate Plan Name

Primary Copay:

☐ $5 ☐ $10

☐ $15 ☐ Other $_____

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time college student.

(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Health Coverage Yes	Other Rx Drug Coverage Yes	Primary Office ID Number	Current Patient Yes	Dentist Office ID Number (If applicable)	Current Patient Yes	Race/Ethnicity - Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)
	Employee	☐ ☐	/ /		☐	☐		☐		☐	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 _____
	Spouse	☐ ☐	/ /		☐	☐		☐		☐	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 _____
	Child	☐ ☐	/ /		☐	☐		☐		☐	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 _____
	Child	☐ ☐	/ /		☐	☐		☐		☐	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 _____
	Child	☐ ☐	/ /		☐	☐		☐		☐	☐ White - 01 ☐ African American or Black - 02 ☐ Hispanic or Latino - 03 ☐ Asian - 04 ☐ Other - 05 _____

Does any dependent listed in above live at a different address than the Employee? If "Yes," who and what address?
☐ Yes ☐ No

Explain the circumstances.

If any dependent's last name differs from yours, explain the circumstances.

Is your Spouse Employed? ☐ Yes ☐ No If "Yes," provide name and address of spouse's employer.

If "Yes" to Other Health Coverage and/or Other Rx Drug Coverage above, provide name & policy number of insurance carrier, HMO, or other source.

If you have questions concerning the benefits provided by or excluded under this Agreement, contact a Member Services representative at 1-800-323-9930 before signing this form.

E. Employee Signature

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 - *Required*
X

Date / /

E-Mail Address

Primary Language Spoken

F. Employer Verification - To Be Completed by Employer

Employer Signature - *Required*
X

Title

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 prior to visiting a specialist or admission to a hospital.

Instructions

Employer

- Complete the **Employer Group Information** at the top of the form.
- Complete **Section F - Employer Verification** in the lower right corner of the form.
  - Employer must complete this section for all new enrollments or coverage changes.
  - Employer must sign and date the Enrollment/Change Request in order for it to be processed.

Employee - Complete Sections A - E.

Section A - Type of Activity:
Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.

Section B - Employee Information:
Complete **all** information in order for your Enrollment/Change Request to be processed.

Section C - Plan Option:
- Select only an option offered by your employer.
- Check one Plan Option box, indicate Plan Option Name (where applicable) and check *one* Primary Copay.

Section D - Individuals Covered:
- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time college student, you **must** attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits).
- If you or your dependent(s) have other Health or Rx Drug Coverage, check the "Yes" box(es) and provide name and policy number of insurance carrier, HMO or other source in the space provided.
- From the appropriate provider directory, locate the **6-digit** office ID number for the primary care physician and/or dentist (if applicable). Indicate office ID number selection(s) on the form.
- If you are a current patient, please check the "Yes" box under Current Patient.
- *Optional* - Indicate the Race/Ethnicity for yourself and your dependents by checking the appropriate box(es). If your Race/Ethnicity is other than the selections listed, please check the "Other" box and print the Race/Ethnicity for yourself and your dependents in the space provided.

Section E - Employee Signature:
- Complete this section for all new enrollments or coverage changes.
- Employee must sign and date the Enrollment/Change Request in order for it to be processed.

Section F - Employer Verification:
- Employer must complete this section for all new enrollments or coverage changes.
- Employer must sign and date the Enrollment/Change Request in order for it to be processed.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
   - HMO: Aetna Health Inc.
   - QPOS/Aetna Choice POS/USAccess: Aetna Health Inc., Corporate Health Insurance Company, Aetna Health Insurance Company of New York, and/or Aetna Health Insurance Company of Connecticut.
2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Request form, including those involving mental health, substance abuse and HIV/AIDS. 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 have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. 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. The plan documents (Schedule of Benefits, Group Agreement, Certificate of Coverage, Group Policy, Group Insurance Certificate) will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.
6. I understand and agree that with the exception of Aetna Rx Home Delivery, all participating providers and vendors are independent contractors and are neither agents 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.
7. I understand and agree that, with certain exceptions described in the plan documents, HMO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.

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 and civil penalties.

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

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 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.