aetna®

Enrollment/Change Request

Aetna Health Inc.

Control	Suffix	Account	Plan Number

Group Number	Class Code

Employer Group Information (To Be Completed by Employer) — Group Name / Employer Name - Full Name of Business or Organization

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 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, Domestic Partner or Legal Partner
☐ Add Dependent Child
☐ Name Change
☐ Other
☐ Change Plan _____
☐ Control/Suffix/Acct/Plan _____

Date of Event / /

Reason _____

Remove or Terminate - *Check all that apply.*

☐ Remove Spouse, Domestic Partner or Legal Partner
☐ 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 (months): ☐ 18 ☐ 36 ☐ Other _____

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

Date of Loss of Coverage / /

Date of Qualifying Event / /

Continuation of Coverage Expiration Date / /

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 Options - Your selection(s) must be offered by your employer.

☐ HMO ☐ QPOS®
☐ Aetna Open Access® HMO
☐ Aetna Choice® POS
☐ AHF Choice® POS
☐ Aetna Health Network Option℠
☐ Aetna Health Network Only℠

Available options with Aetna Health Network Option and Aetna Health Network Only.
Check all that apply.

☐ Aetna HealthFund®
☐ Aexcel®
☐ Aexcel® Plus

Indicate Plan Name

Primary Copay:
☐ $5 ☐ $10
☐ $15 ☐ Other $ _____

A dependent who meets all of the eligibility requirements shall remain eligible for coverage through the last day of the month in which the dependent turns 26 years of age, as long as any change in premium resulting in non-eligibility of the dependent is implemented by the first day of the month following the month in which the dependent child turns 26 years of age.

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. **Provide details for "Yes" responses below.*

(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Other Medical Coverage Yes *	Other Rx Drug Coverage Yes *	Handi-capped Yes N/A	Primary Medical Office ID Number	Current Patient Yes	Dentist Office ID Number (If applicable)	Current Patient Yes	Race/Ethnicity - *Optional* Code	Other
	Employee	☐ ☐	/ /		☐	☐			☐		☐		
	Spouse, Domestic Partner or Legal Partner	☐ ☐	/ /		☐	☐	☐		☐		☐		
	Child	☐ ☐	/ /		☐	☐	☐		☐		☐		
	Child	☐ ☐	/ /		☐	☐	☐		☐		☐		
	Child	☐ ☐	/ /		☐	☐	☐		☐		☐		

(This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)

Using the KEY below, please identify the Race/Ethnicity code for each individual.

KEY:
01 - White
02 - African American or Black
03 - Hispanic or Latino
04 - Asian
05 - Other (Provide race/ethnicity in "Other" column at left)

1. If "Yes" to **Other Medical Coverage** above, provide effective dates, name & policy number of insurance carrier, HMO, or other source and your **Member Identification Number**.

2. If "Yes" to **Other Rx Drug Coverage** above, provide effective dates, name & policy number of insurance carrier, HMO, or other source and your **Member Identification Number**.

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

Explain the circumstances:

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

5. Is your spouse, domestic partner or legal partner employed? ☐ Yes ☐ No If "Yes," provide name and address of spouse, domestic partner or legal partner's employer.

E. Employee Signature

☐ *By checking this box you agree to use Aetna's member self-service website for all future printed materials and understand you may choose to receive paper documents in the future. To view this material please visit Aetna Navigator®.*

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.

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side of this Enrollment/Change Request form.

Employee Signature - *Required*	E-Mail Address	Date	Primary Language Spoken
X		/ /	

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.

Employee - Complete Sections A - E.

Section A - Type of Activity:

- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.
- Provide Effective Date(s) and Date of Event(s) where requested.

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

Section C - Plan Options:

- Select only an option(s) offered by your employer.
- Check *one* Plan Option box in the left column. If you have selected the Aetna Health Network Option or Aetna Health Network Only, check *all that apply* in the right column.
- Where applicable, indicate Plan Option Name 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 you or your dependent(s) have **Other Medical Coverage**, check the "Yes" box and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **Member Identification Number** for the insurance plan in the space provided in Number 1.
- If you or your dependent(s) have **Other Rx Drug Coverage**, check the "Yes" box and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **Member Identification Number** for the insurance plan in the space provided in Number 2.
  - **NOTE**: In some instances your medical carrier will differ from your Rx drug carrier.
- If a dependent is Handicapped and financially dependent, check "Yes" and provide proof of handicapped status from the attending physician.
- Primary Medical Office ID Number/Primary Dental Office ID Number: Locate the office ID number for the primary care physician and/or dentist (if applicable) from the appropriate provider directory or from "DocFind®", Aetna's online provider directory at "www.aetna.com".
- If you are a current patient, please check the "Yes" box under Current Patient.
- *Optional* - Using the KEY provided, please enter the Race/Ethnicity code for each individual. If your Race/Ethnicity is "Other," print the Race/Ethnicity for each individual 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.
- By checking the box on the reverse side you agree to use Aetna Navigator, Aetna's member self-service website, for all future printed materials and understand you may choose to receive paper documents in the future.

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 underwritten or administered by the following entities (collectively referred to as "Aetna"):
   - HMO / Aetna Health Network Only: Aetna Health Inc.
   - QPOS / Aetna Choice POS / Aetna Health Network Option: Aetna Health Inc., Aetna Health Insurance Company, and/or Aetna Life Insurance Company.
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, domestic partner or legal partner 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 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.
6. 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.

Fraud Warning

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.