

Coverage is provided by the following entities: Aetna Health of California Inc. for HMO, Aetna Dental of California Inc. for Dental (DMO only) and Aetna Life Insurance Company for all other coverage.



Small Group Employee Change of Coverage Form – CA

(For Existing Enrollments Only)

TO COMPLY WITH CALIFORNIA LAW: WHEREVER THE TERM "SPOUSE" APPEARS, IT SHALL BE CONSTRUED TO INCLUDE DOMESTIC PARTNER.

Instructions:

Before requesting a different plan, please read the Aetna brochure describing the plan you are thinking of choosing.

Be sure you are acquainted with the benefits, co-payments, annual deductibles and the limitations and exclusions of the plan you choose. The plan you choose must be part of your employer's Small Group benefit coverage.

- You, the employee, must complete this form.** You are solely responsible for its accuracy and completeness.
- All questions must be answered in full and all signatures and dates must be included where noted, otherwise, the form may be returned to you, resulting in a delay in processing and possibly a delay in the effective date of coverage.
- Type or print clearly using blue or black ink.**

1. Choice of Coverage – Please change my coverage to:

| Control/Group No. | Suffix | Account | Plan No. | Class Code | Control/Group No. | Suffix | Account | Plan No. | Control/Group No. | Suffix | Account | Plan No. |
|---|--------|---------|----------|------------|---|--------|---------|----------|-------------------|--|---------|----------|
| 1. Medical - Check one. HMO: <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 40 <input type="checkbox"/> 50 <input type="checkbox"/> Deductible 1000 <input type="checkbox"/> Deductible 1500 <input type="checkbox"/> Coinsurance 70% <input type="checkbox"/> Coinsurance 60% Value NetworkSM HMO: <input type="checkbox"/> 10/20 <input type="checkbox"/> 20/30 <input type="checkbox"/> 30/40 <input type="checkbox"/> 40/50 Vitalidad Mexico HMO: <input type="checkbox"/> 10 Vitalidad Plus HMO: <input type="checkbox"/> 10/5 <input type="checkbox"/> 30/10 MC: <input type="checkbox"/> 250 90/70 <input type="checkbox"/> 2000 80/50/50 <input type="checkbox"/> 250 80/60 <input type="checkbox"/> 2500 75/50 <input type="checkbox"/> 500 80/60 <input type="checkbox"/> 3500 65/50 <input type="checkbox"/> 1000 70/50 <input type="checkbox"/> 4500 60/50 <input type="checkbox"/> 750 80/50/50 <input type="checkbox"/> 7500 75/50 <input type="checkbox"/> 1250 80/50/50 <input type="checkbox"/> 10,000 100/50 <input type="checkbox"/> Value 2250 60/50 <input type="checkbox"/> Value 3750 50/50 <input type="checkbox"/> HSA HDHP 2000 80/50 <input type="checkbox"/> HSA HDHP 3000 90/50 <input type="checkbox"/> HSA HDHP 3500 80/50 <input type="checkbox"/> HRA HDHP 3000 70/50 PPO: <input type="checkbox"/> 750 80/60 Indemnity <input type="checkbox"/> | | | | | 2. Dental - Check one (if applicable). Standard Plans: <input type="checkbox"/> Aetna Dental [®] Plan – Plan Option: _____ For FOC, choose: <input type="checkbox"/> DMO [®] or <input type="checkbox"/> PPO Voluntary Plans: <input type="checkbox"/> Aetna Dental [®] Plan – Plan Option: _____ For FOC, choose: <input type="checkbox"/> DMO [®] or <input type="checkbox"/> PPO Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | 3. Life <input type="checkbox"/> Basic Life/AD&D Ultra [®] <input type="checkbox"/> Optional Dependent Life Beneficiary Designation - Full Name (First, Middle, Last) Beneficiary Social Security Number Relationship to Employee | | |

2. Employee Information – Please complete portion ONLY if a recent change.

| | | | | | | | |
|-----------------------------------|--|----------------|----------|------------------------------------|--|---------------------------------------|----------|
| Last Name, First Name, M.I. | | | | Social Security or ID Number | | | |
| Address (P.O. Box not acceptable) | | | Apt. No. | City, State | | | ZIP Code |
| Home Telephone | | Work Telephone | | No. of Dependents Including Spouse | | Spouse's Social Security or ID Number | |
| Job Title | | Employer Name | | | | No. of Hours Worked Per Week | |

3. Employee/Family Information – List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary. If spouse's last name is different from yours, is he/she a domestic partner? Yes No
NOTE FOR MEDICAL AND DENTAL COVERAGE: While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator. For Dependent Life, dependents are eligible from 14 days of age up to their 19th birthday, or up to their 24th birthday, if a full-time student.

| | | | | | | | | |
|---|-----------------|--------------|--|---|-------------------------------|---|---|---|
| 1. Self Name (Last, First, M.I.) | | | | | Sex (M/F) | Social Security Number | | |
| Birth date (MM/DD/YYYY) | Height (ft, in) | Weight (lbs) | Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated | Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life | PCP Provider Office ID Number | Current Patient <input type="checkbox"/> | Dental Office ID Number (if applicable) | Current Patient <input type="checkbox"/> |

| | | | | | | | | |
|------------------------------------|-----------------|--------------|--|-------------------------------|---|---|---|--|
| 2. Name (Last, First, M.I.) | | | | Sex (M/F) | Social Security Number | | Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____ | |
| Birth date (MM/DD/YYYY) | Height (ft, in) | Weight (lbs) | Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life | PCP Provider Office ID Number | Current Patient <input type="checkbox"/> | Dental Office ID Number (if applicable) | Current Patient <input type="checkbox"/> | |

| | | | | | | | | |
|--|-----------------|--------------|--|-------------------------------|---|---|---|--|
| 3. Child Name (Last, First, M.I.) | | | | Sex (M/F) | Social Security Number | | Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____ | |
| Birth date (MM/DD/YYYY) | Height (ft, in) | Weight (lbs) | Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life | PCP Provider Office ID Number | Current Patient <input type="checkbox"/> | Dental Office ID Number (if applicable) | Current Patient <input type="checkbox"/> | |

| | | | | | | | | |
|--|-----------------|--------------|--|-------------------------------|---|---|---|--|
| 4. Child Name (Last, First, M.I.) | | | | Sex (M/F) | Social Security Number | | Relationship <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____ | |
| Birth date (MM/DD/YYYY) | Height (ft, in) | Weight (lbs) | Coverage Election <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life | PCP Provider Office ID Number | Current Patient <input type="checkbox"/> | Dental Office ID Number (if applicable) | Current Patient <input type="checkbox"/> | |

4. Health History of Members Currently Enrolled - Provide the required medical information if any enrolled family member has been hospitalized, seen a physician or other health care provider or taken prescription medication within the last 6 months.
NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

| Name of Individual | Condition | Medication Prescribed | Dosage | Still Taking Medication |
|--------------------|-----------|-----------------------|--------|--|
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

5. Misrepresentation

Attention California Residents: For your protection, **California** law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

6. Authorization

To the best of my knowledge, I represent that all information supplied in this form is true and complete. I have read and agree to the Authorization Conditions of Enrollment and Misrepresentation on this **California** Small Group Employee Change of Coverage Form.
 I understand in the event I fail to sign and return this form within 31 days of my eligibility date or for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my and my dependents' eligibility may be affected.
 I am employed by the employer shown on Page 1, and I am working full time at least 30 hours per week for this employer at the regular place of business.
CA HMO ENROLLEES - NOTICE OF BINDING ARBITRATION: ANY DISPUTE ARISING FROM OR RELATED TO HEALTH PLAN MEMBERSHIP WILL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE AGREEMENT TO ARBITRATE INCLUDES, BUT IS NOT LIMITED TO, DISPUTES INVOLVING ALLEGED PROFESSIONAL LIABILITY OR MEDICAL MALPRACTICE, THAT IS, WHETHER ANY MEDICAL SERVICES COVERED BY THIS AGREEMENT WERE UNNECESSARY OR WERE UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED. THE HEALTH PLAN AGREEMENT ALSO LIMITS CERTAIN REMEDIES AND MAY LIMIT THE AWARD OF PUNITIVE DAMAGES. SEE THE EVIDENCE OF COVERAGE FOR FURTHER INFORMATION.
 I understand that I am giving up the constitutional right to have disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration. This means that members will not be able to try their case in court. I further understand that the agreement contains limitations on certain remedies and that there may be certain limitations to the recovery of punitive damages.

| | | |
|--------------------------------|---|------------------------------|
| Employee Signature X | Employee E-mail Address (optional) | Date (Month/Day/Year) |
|--------------------------------|---|------------------------------|

