Colorado Small Group Supplemental Employee Enrollment/Change Request
Aetna Life Insurance Company

Instructions: You must complete this enrollment form along with the Colorado Uniform Small Group Employee Application. You alone are responsible for its accuracy and completeness.

A. Employer group information – *To be completed by employer.*

Group name			
Medical – Control number	Suffix	Account number	Plan number

B. Enrollment information

Effective date	**Employee name**	**Social Security number**
Work address		**Date of birth**
Date of hire	**Enrollment** - Check all that apply. ☐ New group enrollment ☐ New hire ☐ Late enrollee ☐ Rehire or reinstatement ☐ Other _____	

C. Coverage selection – *Please print clearly, using black ink.*

Medical ☐ Yes ☐ No

☐ Employee ☐ Spouse or partner ☐ Children

☐ **Open Access (OA) EPO** – Plan name _____

Aetna Life Insurance Company underwrites the Open Access (OA) EPO plans.

D. Changes – *Check all that apply.*

NOTE: 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. Please refer to your plan documents or contact your benefits administrator.

Transaction: ☐ **Add** ☐ **Add child*** ☐ **Name change** ☐ **Change plan** ☐ **PCP selection** ☐ **Other** _____

Name	**Date of birth**	**Social Security number**	**Date of event**	**Reason**	**Primary care provider number**	**Current patient**
						☐ Yes
						☐ Yes
						☐ Yes
						☐ Yes
						☐ Yes
						☐ Yes

Employee must be enrolled for spouse or dependents to enroll for coverage.

E. Remove or terminate – *Check all that apply.*

	Date of event	**Reason**
☐ Employee termination		
☐ Remove spouse or partner		
☐ Remove child: name _____		
☐ Cancel coverage		

F. COBRA or state continuation – *Check all that apply.*

☐ Employee ☐ COBRA ☐ State continuation Qualifying event: _____ Start date: _____ Stop date: _____	☐ Dependent name: _____ ☐ COBRA ☐ State continuation Qualifying event: _____ Start date: _____ Stop date: _____	☐ Dependent name: _____ ☐ COBRA ☐ State continuation Qualifying event: _____ Start date: _____ Stop date: _____

Conditions of enrollment

I understand that Aetna Life Insurance Company underwrites the plan I apply for.

1. My employer's application determines coverage. I don't have coverage until Aetna approves my employee enrollment form and the employer application. Even if Aetna approves the employer application, any misstatements or omissions may result in denial of future claims. Aetna may rescind or reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Aetna will give at least 30 days advance written notice to any covered person affected by the proposed rescission. If I elect to receive electronic notifications, I will receive this notice in an electronic (email) format.
2. In order to underwrite the coverages listed on this enrollment, Aetna may need information about medical history, services or treatment provided to anyone listed on this form. This may include information about mental health, substance use disorder and HIV / AIDS. I authorize that the following entities can provide this information to Aetna or its agents:
   - Physicians
   - Other healthcare professionals
   - Hospitals
   - Other healthcare organizations ("providers"), including
     - Pharmacies
     - Pharmacy database benefit managers
3. I authorize Aetna to use and disclose such information to:
   - Affiliates
   - Providers
   - Other insurers
   - Third party administrators
   - Vendors
   - Consultants
   - Governmental authorities with jurisdiction when necessary for:
     - Care or treatment
     - Payment for services
     - Operation of my health plan
     - Conduct related activities
4. I discussed the terms of this authorization with my competent adult dependents. They agreed to these terms. This authorization is valid for the term of the coverage or so long thereafter as allowed by law. This authorization is voluntary. But if I don't sign this form, my ability to enroll in the plan may be affected. I have the right to revoke this authorization in writing to Aetna at any time. I can't revoke authorization for information already used or disclosed before I revoked my authorization. I am entitled to receive a copy of this authorization upon request. A photocopy is as valid as the original.
   - The Group Agreement / Group Policy determines the rights and responsibilities of members and will govern in the event they conflict with any:
     - Benefits comparison
     - Summary
     - Other description of the plan
   - Participating physicians, hospitals and other health care providers are independent contractors. They are not Aetna agents or employees. We cannot guarantee the availability of any particular provider. Any provider network is subject to change. We will provide a notice of the change in accordance with applicable state law.
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. **COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY APPLICABLE HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO ANY SMALL EMPLOYER THAT APPLIES FOR THE PLAN AND AGREES TO MAKE THE REQUIRED PREMIUM PAYMENTS, AND SATISFIES THE OTHER PROVISIONS OF THE HEALTH BENEFIT PLAN.**

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Misrepresentation

ATTENTION: 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.

I represent that all information supplied in this form is true and complete. I have read and agree to the conditions of enrollment and misrepresentation on this Small Group Supplemental Employee Enrollment / Change Request.

I understand that, if I don't sign this form within 31 days, or Aetna does not receive the request within a reasonable time, my eligibility may be affected. I am employed by the employer shown on page 1. I am working full time at least 25 hours a week for this employer at the regular place of business. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.

To receive documents online, please go to your secure member account at aetna.com

Employee signature	*Employee email*	*Date (Month/Day/Year)*
X		