District of Columbia Small Group Employee Enrollment/Change Form

For dental and vision group coverage

Aetna Life Insurance Company

Group number
Aetna member ID number (if available)

INSTRUCTIONS: You must complete this enrollment form in full. If you do not, we will return it to you, and that can delay its processing. You alone are responsible for its accuracy and completeness. **If you are declining coverage, you must complete Section B.** Please use only black ink to complete this form.

Company name			
Effective date **Date of hire**	☐ New hire ☐ Rehire / reinstatement ☐ New group enrollment ☐ Late enrollment ☐ Waiver ☐ Open enrollment ☐ Loss of coverage	☐ Add spouse ☐ Add domestic partner or legal partner ☐ Add dependent child ☐ Change of coverage ☐ Name change	☐ Employee termination date _____ ☐ Remove spouse ☐ Remove domestic partner or legal partner ☐ Remove dependent child ☐ Cancel coverage ☐ Other _____

A. Employee information – *You must complete this section. Please print clearly, using black ink.*

Social Security number	Last name, first name, middle initial		Job title
Home address	Apt. number	City, state	ZIP code
Work address		City, state	ZIP code
Home telephone ( ) -	Work telephone ( ) -	Primary language spoken (optional)	Number of dependents, including spouse or domestic partner or legal partner, enrolling for medical coverage
Salary $ _____ ☐ Hourly ☐ Weekly ☐ Monthly	Number of hours worked a week	Check one: ☐ Full time ☐ Part time ☐ 1099 ☐ Retiree ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union	

B. Declining coverage – *Check all that apply.*

I understand I am eligible to apply for this coverage through my employer. However, I am declining the coverage I checked below:

☐ Employee:	☐ Dental	☐ Vision
☐ Spouse / domestic partner / legal partner:	☐ Dental	☐ Vision
☐ Children:	☐ Dental	☐ Vision

Reason for declining coverage

- ☐ Parental group coverage
- ☐ Spouse / domestic partner / legal partner group coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Retiree coverage
- ☐ COBRA coverage
- ☐ Insurance through another job
- ☐ TRICARE / Military coverage
- ☐ Individual coverage – On Exchange
- ☐ Individual coverage – Off Exchange
- ☐ Another group plan provided by my employer
- ☐ Do not want
- ☐ Other _____

I represent I have been given the right to apply for this coverage. However, I am declining coverage as noted above. By declining this group coverage, I acknowledge that I and / or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Please sign here ONLY if you are declining coverage for yourself and / or dependents.	***Date (Month/Day/Year)***
☐ I am declining coverage. **Employee signature:** X	
Please PRINT employee name:	

C. Coverage selection – *Top boxes for employer and Aetna use only*

Control/Group number	Suffix	Account	Plan number

1. Dental ☐ Yes ☐ No *To enroll, enter the plan number and name below.*

Non-voluntary plans – Plan number _____ Plan name _____

If Freedom-of-Choice, check: ☐ DMO® *or* ☐ PPO

Voluntary plans – Plan number _____ Plan name _____

If Freedom-of-Choice, check: ☐ DMO® *or* ☐ PPO

Before today, were you covered under this employer's dental plan? ☐ **Yes** ☐ **No**

Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires please see below if applicable:
New Hire selecting a Voluntary plan **and your Aetna plan is a takeover group**: Were you covered for 12 months under a dental plan within the last 90 days that included both Preventive and basic coverage? Discount dental and preventive only plans do not apply. ☐ Yes ☐ No

Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®.

Aetna Life Insurance Company underwrites Aetna dental plans.

Control/Group number	Suffix	Account	Plan number

2. Aetna Vision℠ Preferred ☐ Yes ☐ No

Aetna Life Insurance Company underwrites Aetna vision plans. First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.

D. Individuals covered – *List individuals for whom you are enrolling or adding, changing or removing coverage. Add more sheets if needed.*

NOTE FOR MEDICAL COVERAGE: While the 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.

1	☐ Add ☐ Change ☐ Remove	**Employee name** (Last, first, middle initial)	Sex (M/F)
Birthdate (MM/DD/YYYY) / /	Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated	Choosing coverage for: ☐ Dental ☐ Vision	
Dental provider office ID number		Current patient ☐ Yes	

2	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Spouse** ☐ **Domestic partner** ☐ **Legal partner**	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Choosing coverage for: ☐ Dental ☐ Vision		
Dental provider office ID number		Current patient ☐ Yes		

3	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /	Incapacitated ☐ Yes ☐ No	Choosing coverage for: ☐ Dental ☐ Vision		
Dental provider office ID number		Current patient ☐ Yes		

4	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /	Incapacitated ☐ Yes ☐ No	Choosing coverage for: ☐ Dental ☐ Vision		
Dental provider office ID number		Current patient ☐ Yes		

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D. Individuals covered *(Continued)*

5	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated ☐ Yes ☐ No	Choosing coverage for: ☐ Dental ☐ Vision	
Dental provider office ID number			Current patient ☐ Yes	

6	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Child** ☐ **Stepchild** ☐ **Other** _____	Sex (M/F)	Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated ☐ Yes ☐ No	Choosing coverage for: ☐ Dental ☐ Vision	
Dental provider office ID number			Current patient ☐ Yes	

E. Dependent information

List any dependent in Section **D** with a different last name or living at another address.

Name	Address

Conditions of enrollment

I understand that the following legal entity underwrites the dental and vision plans I apply for: Aetna Life Insurance Company.

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. To support the coverages listed on this enrollment form, 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 administration
   - Vendors
   - Consultants
   - Governmental authorities with jurisdiction when necessary for:
     - Care or treatment
     - Payment for services
     - Operation of my health plan
     - Conduct related activities

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Conditions of enrollment *(Continued)*

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 for medical information collected in connection with a medical claim. 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 understand that, with certain exceptions described in the plan documents, DMO© plans only provide coverage for network covered benefits. The plan documents also describe if I need a referral for certain procedures, and who can provide care. Covered services must be performed by:
   - Participating primary care physicians
   - Participating primary care dentists
   - Participating specialists
   - Participating hospitals
   - Participating pharmacies
   - Participating dentists
   - Other participating providers as authorized by a referral from a participating primary care physician
6. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.

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 Employee Enrollment / Change Form.

I understand that if I do not 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 30 hours a week 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 visit your secure member account at aetna.com.

Misrepresentation: 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.

Please sign here ONLY if you are enrolling in coverage for yourself and / or dependents. ***Employee signature (required)***	***Employee email***	***Date (Month/Day/Year)***