



Dental Enrollment/Change Request

Aetna Life Insurance Company*

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.

	Control	Suffix	Account	Plan number
Employer group information – To be completed by employer.				
Employer name – full name of business or organization				
Employer address (street, city, state, ZIP code) – primary location of business or organization				

A. Type of activity – Employee completes sections A – E. Please print clearly.

Enrollment – Check one. <input type="checkbox"/> New enrollee / subscriber Effective date: ____/____/____ Date of hire: ____/____/____ <input type="checkbox"/> Rehire / reinstatement Date of rehire / reinstatement: ____/____/____	Change – Check all that apply. <input type="checkbox"/> Add spouse <input type="checkbox"/> Add dependent child <input type="checkbox"/> Name change <input type="checkbox"/> Other _____ <input type="checkbox"/> Control / Suffix / Acct / Plan _____ Date of event: _____ Reason: _____	Remove or terminate – Check all that apply. <input type="checkbox"/> Remove spouse <input type="checkbox"/> Remove dependent child <input type="checkbox"/> Employee withdrawal / termination <input type="checkbox"/> Cancel coverage Effective date: _____ Reason: _____	Continuation of coverage, i.e., COBRA, state <i>Not all options are available. Contact employer for available options.</i> Coverage for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of continuation (months): <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other ____ <input type="checkbox"/> 29 – Attach disability determination from the Social Security Administration Date of loss of coverage: _____ Date of qualifying event: _____ Continuation of coverage expiration date: _____
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B. Employee information

Social Security number	Last name, first name, middle initial	Home telephone () -	Work telephone () -
Employee status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Employee home address	Apt. number	City, state
		ZIP code	

C. Plan options – Check one. Your selection must be offered by your employer.

<input type="checkbox"/> Indemnity Dental	<input type="checkbox"/> Dental EPP	<input type="checkbox"/> FOC / Indemnity
<input type="checkbox"/> DentalFund / HealthFund	<input type="checkbox"/> DMO® / Advantage / Basic	<input type="checkbox"/> FOC / PPO
<input type="checkbox"/> Dental PPO		<input type="checkbox"/> FOC / DMO®

D. Individuals covered – List individuals for whom you are enrolling or adding / changing / removing coverage.

Check this box if you are refusing coverage for your dependents. * Provide details for "Yes*" responses below.

Add Change ____ Remove	1. Employee name - Last name, first name, middle initial	Relation code Self	Sex (M/F)	Birthdate (MM/DD/YYYY) / /									
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Social Security number</td> <td style="width: 10%;">Late entrant Yes <input type="checkbox"/></td> <td style="width: 10%;">Prior insur. plan Yes* <input type="checkbox"/></td> <td style="width: 10%;">Other dental coverage Yes* <input type="checkbox"/></td> <td style="width: 10%;">Currently covered by Medicare Yes* <input type="checkbox"/></td> <td style="width: 10%;">Handi-capped N/A</td> <td style="width: 10%;">Student N/A</td> <td style="width: 10%;">Primary dentist office ID number</td> <td style="width: 10%;">Current patient Yes <input type="checkbox"/></td> </tr> </table>	Social Security number	Late entrant Yes <input type="checkbox"/>	Prior insur. plan Yes* <input type="checkbox"/>	Other dental coverage Yes* <input type="checkbox"/>	Currently covered by Medicare Yes* <input type="checkbox"/>	Handi-capped N/A	Student N/A	Primary dentist office ID number	Current patient Yes <input type="checkbox"/>			
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	2. Spouse name - Last name, first name, middle initial (Explain difference in last name in Special remarks.)	Relation code	Sex (M/F)	Birthdate (MM/DD/YYYY) / /									
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Social Security number (if dependent has no SSN, write "None")</td> <td style="width: 10%;">Late entrant Yes <input type="checkbox"/></td> <td style="width: 10%;">Prior insur. plan Yes* <input type="checkbox"/></td> <td style="width: 10%;">Other dental coverage Yes* <input type="checkbox"/></td> <td style="width: 10%;">Currently covered by Medicare Yes* <input type="checkbox"/></td> <td style="width: 10%;">Handi-capped Yes <input type="checkbox"/></td> <td style="width: 10%;">Student Yes <input type="checkbox"/></td> <td style="width: 10%;">Primary dentist office ID number</td> <td style="width: 10%;">Current patient Yes <input type="checkbox"/></td> </tr> </table>	Social Security number (if dependent has no SSN, write "None")	Late entrant Yes <input type="checkbox"/>	Prior insur. plan Yes* <input type="checkbox"/>	Other dental coverage Yes* <input type="checkbox"/>	Currently covered by Medicare Yes* <input type="checkbox"/>	Handi-capped Yes <input type="checkbox"/>	Student Yes <input type="checkbox"/>	Primary dentist office ID number	Current patient Yes <input type="checkbox"/>			
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Continued on page 2

D. Individuals covered (Continued) – List individuals for whom you are enrolling or adding / changing / removing coverage.

** Provide details for “Yes” responses below. Attach sheet to list additional children.*

Add Change ___ Remove	3. Child name - Last name, first name, middle initial (Explain difference in last name in Special remarks.)					Relation code	Sex (M/F)	Birthdate (MM/DD/YYYY) / /	
Social Security number (if dependent has no SSN, write “None”)	Late entrant Yes <input type="checkbox"/>	Prior insur. plan Yes* <input type="checkbox"/>	Other dental coverage Yes* <input type="checkbox"/>	Currently covered by Medicare Yes* <input type="checkbox"/>	Handi-capped Yes <input type="checkbox"/>	Student Yes <input type="checkbox"/>	Primary dentist office ID number	dentist office ID	Current patient Yes <input type="checkbox"/>
Add Change ___ Remove	4. Child name - Last name, first name, middle initial (Explain difference in last name in Special remarks.)					Relation code	Sex (M/F)	Birthdate (MM/DD/YYYY) / /	
Social Security number (if dependent has no SSN, write “None”)	Late entrant Yes <input type="checkbox"/>	Prior insur. plan Yes* <input type="checkbox"/>	Other dental coverage Yes* <input type="checkbox"/>	Currently covered by Medicare Yes* <input type="checkbox"/>	Handi-capped Yes <input type="checkbox"/>	Student Yes <input type="checkbox"/>	Primary dentist office ID number	dentist office ID	Current patient Yes <input type="checkbox"/>
Add Change ___ Remove	5. Child name - Last name, first name, middle initial (Explain difference in last name in Special remarks.)					Relation code	Sex (M/F)	Birthdate (MM/DD/YYYY) / /	
Social Security number (if dependent has no SSN, write “None”)	Late entrant Yes <input type="checkbox"/>	Prior insur. plan Yes* <input type="checkbox"/>	Other dental coverage Yes* <input type="checkbox"/>	Currently covered by Medicare Yes* <input type="checkbox"/>	Handi-capped Yes <input type="checkbox"/>	Student Yes <input type="checkbox"/>	Primary dentist office ID number	dentist office ID	Current patient Yes <input type="checkbox"/>
Add Change ___ Remove	6. Child name - Last name, first name, middle initial (Explain difference in last name in Special remarks.)					Relation code	Sex (M/F)	Birthdate (MM/DD/YYYY) / /	
Social Security number (if dependent has no SSN, write “None”)	Late entrant Yes <input type="checkbox"/>	Prior insur. plan Yes* <input type="checkbox"/>	Other dental coverage Yes* <input type="checkbox"/>	Currently covered by Medicare Yes* <input type="checkbox"/>	Handi-capped Yes <input type="checkbox"/>	Student Yes <input type="checkbox"/>	Primary dentist office ID number	dentist office ID	Current patient Yes <input type="checkbox"/>

1. If **yes** to **Prior insurance plan** and / or **Other medical coverage** above, provide effective dates, name and policy number of insurance carrier, HMO, or other source and your **member identification number**.

2. If **yes** to **Other dental coverage** and / or **Currently covered by Medicare** above, provide effective dates, name and policy number of insurance carrier, dental plan 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?

Special remarks:

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 1. <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____	Child 4. <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____
Spouse 2. <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____	Child 5. <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____
Child 3. <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____	Child 6. <input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____

Conditions of enrollment

Applicant acknowledgments and agreements

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

1. *I acknowledge that by enrolling in the following plans, Aetna Life Insurance Company (collectively known as Aetna) underwrites or administers coverage for Aetna DMO, Aetna Dental PPO, Dental EPP, Aetna HealthFund / Aetna DentalFund, and Aetna Indemnity Dental.
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 I am entitled to a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents 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 (including all participating primary care dentists) 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.

E. Employee signature *By checking this box you agree to use our member self-service website for all future printed materials.*

I represent 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 this Employee Enrollment / Change Request form. I understand that in the event I fail to sign this form within 31 days after the above transaction request or that 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.

Misrepresentation: 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 may have violated state law.

<i>Employee signature - required</i>	<i>Date (Month/Day/Year)</i>	<i>Employee email address (optional)</i>	<i>Primary language spoken</i>
X			

Corporate headquarters

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Please make a copy for your records. Visit us at www.aetna.com.

Instructions

Employer – Complete the **Employer group information** at the top of page 1.

Employee – Complete sections A – E.

Section A – Type of activity:

- Check boxes indicating reasons for submitting this Enrollment / Change Request.
- Provide Effective dates and Date of events 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 offered by your employer.

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 names(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security number for each individual.
- *Relationship code* – Use **ONLY**: H=Husband, W=Wife, S=Son, D=Daughter, Y=Sponsored male, X=Sponsored female. **If the dependent is NOT your spouse or a biological or legally adopted child, please indicate relationship to employee in Special remarks.**
- **Late entrant:** If you are **not** enrolling within your employer’s eligible enrollment period, check **Yes**.
- If you or your dependent(s) were covered under your employer’s or other **Prior insurance plan**, check the **Yes** boxes and provide beginning and ending effective dates, name and policy number of insurance carrier, dental plan 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 dental coverage** and / or are **Currently covered by Medicare**, check the **Yes** boxes) and provide beginning and ending effective dates, name and policy number of insurance carrier, dental plan or other source and your **member identification number** for the insurance plan in the space provided in number 2.
- If a dependent is handicapped and financially dependent, check **Yes** and provide proof of handicapped status from the attending physician.
- If a dependent is a student, check **Yes**. Refer to your Summary Coverage for plan definitions. Aetna may request that you provide proof from the educational institution.
- Primary dentist office ID number: Locate the office ID number for the primary dentist from the appropriate provider directory or from the 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 provided, you agree to use our member self-service website for all future printed materials.