Georgia
Employee Enrollment/Change Form

Aetna Life Insurance Company Aetna Health Inc. Aetna Health Insurance Company

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 C.** Please use only black ink to complete this form.

Employer group information – To be completed by employer	Aetna member ID number (if available)

Employer / company 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 – F. *Please print clearly.*

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 ☐ Add dependent child ☐ Change of coverage ☐ Name change	☐ Employee termination date _____ ☐ Remove spouse ☐ Remove domestic partner ☐ Remove dependent child ☐ Cancel coverage ☐ Other _____

☐ **COBRA** ☐ **State continuation** for: ☐ Employee ☐ Dependent Length of continuation: ☐ 18 months ☐ 36 months ☐ Other ____
Qualifying event _____ Original qualifying event date _____ Loss of coverage date _____

B. Employee information – *You must complete this section.*

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 / cell telephone ( ) -	Work telephone ( ) -	Number of hours worked a week	Employee email
Primary language spoken (optional)	Check one: ☐ Full time ☐ Part time ☐ 1099 ☐ Retiree ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union		

C. 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:	☐ Medical ☐ Vision	☐ Dental	**Reason for declining coverage** ☐ Parental group coverage ☐ Spouse / domestic partner group coverage ☐ Medicare ☐ Medicaid ☐ Retiree coverage ☐ COBRA coverage
☐ Spouse / domestic partner:	☐ Medical ☐ Vision	☐ Dental	
☐ Children:	☐ Medical ☐ Vision	☐ Dental	☐ 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 certify I have 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:	

D. Plan Options – Check one plan. ***Your selection must be offered by your employer.***

Control number	Suffix	Account	Plan number	Customer Code

1. Medical ☐ Yes ☐ No *To enroll, check "yes" and enter the plan option elected below. Please print clearly.*

Plan option _____

You may only select a plan offered by your employer.

Aetna Life Insurance Company, Aetna Health Inc. and / or Aetna Health Insurance Company underwrite / administer medical coverage.

Control number	Suffix	Account	Plan number

2. Dental ☐ Yes ☐ No *To enroll, check "yes" and enter the plan option elected below. Please print clearly.*

Plan option / name _____ If FOC, choose: ☐ DMO® *or* ☐ PPO / Indemnity

You may only select a dental plan if your employer offers dental coverage.

Before today, were you covered under this employer's dental plan? ☐ 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®.

For groups 51-100 only:

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

Aetna Health Inc. underwrites the Aetna DMO® dental plans. Aetna Life Insurance Company underwrites all other Aetna dental plans.

Control number	Suffix	Account	Plan number

3. Aetna Vision℠ Preferred ☐ **Yes** ☐ **No** *To enroll, check "yes" and enter the plan option elected below. Please print clearly.*

Plan option / name _____

You may only select a vision plan if your employer offers vision coverage.

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

E. Individuals covered – ***List individuals for whom you are enrolling or adding, changing or removing coverage. Please complete all information for all individuals. 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. Enter domestic partner only if your employer has elected that coverage.

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: ☐ Medical ☐ Dental ☐ Vision	
Primary care physician (PCP) provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes

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

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E. Individuals covered *(Continued)*

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: ☐ Medical ☐ Dental ☐ Vision		
PCP provider ID number		Current patient ☐ Yes	Dental provider office ID number		Current patient ☐ Yes

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: ☐ Medical ☐ Dental ☐ Vision		
PCP provider ID number		Current patient ☐ Yes	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: ☐ Medical ☐ Dental ☐ Vision		
PCP provider ID number		Current patient ☐ Yes	Dental provider office ID number		Current patient ☐ Yes

F. Dependent information

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

Name	Address

G. Coordination of benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No

If **yes**, will the Aetna coverage you're applying for replace the coverage you have now? ☐ Yes ☐ No

Name of person	Carrier name	Name of person	Carrier name

Disclosure acknowledgment

I understand that I am enrolling in a health care plan issued by Aetna Health Inc. or Aetna Life Insurance Company ("Aetna") that requires health care services be provided by participating providers. Failure to use a participating provider will result in reduced coverage or no coverage for services that I receive, and I will be fully responsible for any and all costs not covered by Aetna.

I received a list of participating providers. I may verify the participation status of a provider by using the provider search at Aetna's web site, **http://www.aetna.com**. The provider search site is updated weekly and can also be used to select a provider based on name, geographic location, group practice, medical specialty and / or hospital affiliation. I may also verify provider status by contacting Member Services at the number listed on my member ID card. I understand that the participation status of any provider may change from time to time and that it is my responsibility to verify participation of my health care provider with Aetna prior to receiving services.

As required by the state of Georgia regulations, the following is a summary of the financial arrangements with health care providers who are participating in the Aetna Health Inc. network:

1. Hospital providers are paid according to a contract that includes inpatient per diems, case rates, and discounted fee for service arrangements depending on the specific services provided.
2. Physicians are paid either a discounted fee for service in accordance with a specific fee schedule or a predetermined set amount per member per month (capitation).
3. Laboratory services are provided through a capitation arrangement (a per member per month flat fee).
4. Other ancillary services including home health, skilled nursing, and hospice are paid on a contracted fee schedule with per diems or per visit amounts, or through a capitated per member per month flat fee.

Conditions of enrollment

I acknowledge that by enrolling in an Aetna plan, coverage is underwritten or administered by Aetna Life Insurance Company, Aetna Health Inc. and / or Aetna Health insurance Company (referred to as "Aetna"). For Vision coverage, First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.

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, material 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 minimally necessary information about mental health, substance use disorder and HIV / AIDS. In accordance with HIPAA regulations, 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. In accordance with HIPAA regulations, I authorize Aetna to use and disclose such minimally necessary 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
   - 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.

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Conditions of enrollment *(Continued)*

4. I discussed the terms of this authorization with my competent adult dependents. This authorization is valid for 30 months from the signature date. 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
5. I understand that, with certain exceptions described in the plan documents, HMO and DMO© plans only provide coverage for 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 to the best of my knowledge and belief. I agree to the conditions of enrollment and misrepresentation on this Employee Enrollment Form. 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 authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments required for coverage.

I have read and understand the information provided in the Disclosure section of this form.

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

Misrepresentation: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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