



Employee Enrollment/Change Request

Aetna Health Inc.

Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156

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
Group Number			Class Code

Employer Group Information (To Be Completed by Employer)

Group/Employer Name – Full Name of Business or Organization

A. Type of Activity – Employee Completes Sections A – E. Please Print Clearly.

Enrollment <input type="checkbox"/> New Enrollee/Subscriber Effective Date: ____/____/____ Date of Hire: ____/____/____	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"/> Change Plan: _____ <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 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, M.I.		Home Telephone
Home Address	Apt. No.	City, State	ZIP Code
Employer Name	Work Telephone		
Work Address	City, State		ZIP Code

C. Plan Options – Your selection(s) must be offered by your employer.

<input type="checkbox"/> HMO <input type="checkbox"/> QPOS® <input type="checkbox"/> Aetna Open Access® HMO <input type="checkbox"/> Aetna Choice® POS <input type="checkbox"/> AHF Choice® POS <input type="checkbox"/> Aetna Health Network Option SM <input type="checkbox"/> Aetna Health Network Only SM	Available options with Aetna Health Network Option and Aetna Health Network Only. <i>Check one.</i> <input type="checkbox"/> Aetna HealthFund® <input type="checkbox"/> Aexcel® <input type="checkbox"/> Aexcel® Plus	Indicate Plan Name Primary Copay <input type="checkbox"/> \$5 <input type="checkbox"/> \$10 <input type="checkbox"/> \$15 <input type="checkbox"/> Other \$ ____
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While the Federal Patient Protection and Affordable Care Act generally 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.

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

*Provide details for "Yes" responses below.

(A)dd (C)hange (R)emove	1. Employee Name (Last, First, M.I.)				Sex (M/F)	Birthdate (MM/DD/YYYY) ____/____/____	
Social Security Number	Other Medical Coverage Yes* <input type="checkbox"/>	Other Rx Drug Coverage Yes* <input type="checkbox"/>	Handicapped N/A	Primary Medical Office ID Number	Current Patient Yes <input type="checkbox"/>	Dental Office ID Number (if applicable)	Current Patient Yes <input type="checkbox"/>

Continued on Page 2

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Aetna prior to visiting a specialist or admission to a hospital.

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

**Provide details for “Yes” responses below.*

(A)dd (C)hange _____ (R)emove	2. Spouse Name (Last, First, M.I.)				Sex (M/F)	Birthdate (MM/DD/YYYY) / /		
Social Security Number		Other Medical Coverage Yes* <input type="checkbox"/>	Other Rx Drug Coverage Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	Primary Medical Office ID Number	Current Patient Yes <input type="checkbox"/>	Dental Office ID Number (if applicable)	Current Patient Yes <input type="checkbox"/>
(A)dd (C)hange _____ (R)emove	3. Child Name (Last, First, M.I.)				Sex (M/F)	Birthdate (MM/DD/YYYY) / /		
Social Security Number (if dependent has no SSN, write “None”)		Other Medical Coverage Yes* <input type="checkbox"/>	Other Rx Drug Coverage Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	Primary Medical Office ID Number	Current Patient Yes <input type="checkbox"/>	Dental Office ID Number (if applicable)	Current Patient Yes <input type="checkbox"/>
(A)dd (C)hange _____ (R)emove	4. Child Name (Last, First, M.I.)				Sex (M/F)	Birthdate (MM/DD/YYYY) / /		
Social Security Number (if dependent has no SSN, write “None”)		Other Medical Coverage Yes* <input type="checkbox"/>	Other Rx Drug Coverage Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	Primary Medical Office ID Number	Current Patient Yes <input type="checkbox"/>	Dental Office ID Number (if applicable)	Current Patient Yes <input type="checkbox"/>
(A)dd (C)hange _____ (R)emove	5. Child Name (Last, First, M.I.)				Sex (M/F)	Birthdate (MM/DD/YYYY) / /		
Social Security Number (if dependent has no SSN, write “None”)		Other Medical Coverage Yes* <input type="checkbox"/>	Other Rx Drug Coverage Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	Primary Medical Office ID Number	Current Patient Yes <input type="checkbox"/>	Dental Office ID Number (if applicable)	Current Patient Yes <input type="checkbox"/>
(A)dd (C)hange _____ (R)emove	6. Child Name (Last, First, M.I.)				Sex (M/F)	Birthdate (MM/DD/YYYY) / /		
Social Security Number (if dependent has no SSN, write “None”)		Other Medical Coverage Yes* <input type="checkbox"/>	Other Rx Drug Coverage Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	Primary Medical Office ID Number	Current Patient Yes <input type="checkbox"/>	Dental Office ID Number (if applicable)	Current Patient Yes <input type="checkbox"/>
1. If “Yes” to Other Medical Coverage above, provide effective dates, name & policy number of insurance carrier, HMO, or other source & your Member Identification Number .								
2. If “Yes” to Other Rx Drug Coverage above, provide effective dates, name & policy number of insurance carrier, HMO, or other source & your Member Identification Number .								
3. Does any dependent listed above live at a different address than the employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If “Yes,” who & what address? Briefly explain circumstances.								
4. Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If “Yes,” provide name & address of spouse’s employer.								

E. Race/Ethnicity - Optional (This information is designed for the purpose of data collection & 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 on Pages 1 and 2, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is underwritten or administered by the following entities (collectively referred to as "Aetna").
 - HMO / Aetna Health Network Only: Aetna Health Inc.
 - QPOS / Aetna Choice POS / Aetna Health Network Option: Aetna Health Inc., Aetna Health Insurance Company and/or Aetna Life Insurance Company.
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. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law which in no event shall be more than twenty-four (24) months. Subject to the rights of an individual who acted in reliance on the authorization, I may revoke this authorization, at any time, by providing written notice to Aetna Life Insurance Company. 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 (Schedule of Benefits, Group Agreement, Certificate of Coverage, Group Policy, Group Insurance Certificate) 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 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.
6. I understand and agree that, with certain exceptions described in the plan documents, HMO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.
7. All statements within the application shall be deemed to be representations and not warranties.

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 commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

By checking this box you agree to use Aetna's member self-service website for all future printed materials and understand you may choose to receive paper documents in the future. To view this material please visit www.aetna.com.

Employee Signature

I certify 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 and Misrepresentation on this Employee Enrollment/Change Request form.

If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Member Services representative at 1-800-323-9930 before signing this form.

<i>Employee Signature - Required</i>	<i>Date (Month/Day/Year)</i> / /	<i>Employee E-mail Address (optional)</i>	<i>Primary Language Spoken</i>
X			

Employer Verification (To Be Completed by Employer)

<i>Employer Signature - Required</i>	<i>Title</i>	<i>Date (Month/Day/Year)</i> / /
X		

Instructions

Employer

- Complete the **Employer Group Information** at the top of Page 1.
- Complete the **Employer Verification** below the Employee signature on Page 3. Employer must sign & date the Enrollment/Change Request for new enrollments or coverage changes to be processed.

Employee – Complete Sections A – E. Additional dependent and/or other information may be provided on a separate sheet of paper. All attachments must be signed and dated.

Section A – Type of Activity:

- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.
- Provide Effective Date(s) & Date of Event(s) where requested.

Section B – Employee Information: Complete **all** information in order for your Enrollment/Change Request to be processed.

Section C – Plan Options:

- Your selection(s) must be offered by your employer.
- Check *one* Plan Option box in the left column. If you have selected the Aetna Health Network Option or Aetna Health Network Only, check *one option* in the right column.
- Where applicable, indicate Plan Option Name & check *one* Primary Copay.

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, & Social Security Number for each individual listed.
- If you or your dependent(s) have **Other Medical Coverage**, check the “Yes” box and provide beginning & ending effective dates, name & policy number of insurance carrier, HMO or other source & your **Member Identification Number** for the insurance plan in the space provided in Number 1.
- If you or your dependent(s) have **Other Rx Drug Coverage**, check the “Yes” box and provide beginning & ending effective dates, name & policy number of insurance carrier, HMO or other source & your **Member Identification Number** for the insurance plan in the space provided in Number 2.
 - **NOTE:** In some instances your medical carrier will differ from your Rx drug carrier.
- If a dependent is Handicapped & financially dependent, check “Yes” & provide proof of handicapped status from the attending physician.
- Primary Medical Office ID Number/Dental Office ID Number: Locate the office ID number for the primary care physician &/or dentist (if applicable) from the appropriate provider directory or from DocFind®, Aetna’s online provider directory at www.aetna.com.
- If you are a current patient, please check the “Yes” box under Current Patient.

Section E – Race/Ethnicity (Optional): Check the appropriate Race/Ethnicity code for each individual. If your Race/Ethnicity is “Other,” print the Race/Ethnicity for each individual in the space provided.

Conditions of Enrollment/Misrepresentation – Employee Signature:

- Complete this section for all new enrollments or coverage changes.
- Employee must sign & date the Enrollment/Change Request for new enrollments or coverage changes to be processed.
- By checking the box above this section you agree to use Aetna’s member self-service website, for all future printed materials and understand you may choose to receive paper documents in the future.