Enrollment/Change Request
Aetna Life Insurance Company

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

TO COMPLY WITH NEW HAMPSHIRE LAW, WHEREVER THE TERM "SPOUSE" APPEARS, IT WILL BE CONSTRUED TO INCLUDE CIVIL UNION PARTNER.

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
Customer code (optional)			

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.*
- ☐ New enrollee/subscriber
  - **Effective date:** ____/____/____
  - **Date of hire:** ____/____/____
- ☐ Rehire/reinstatement
  - **Date of rehire/ reinstatement** ____/____/____

Change – *Check all that apply.*
- ☐ Add spouse
- ☐ Add dependent child
- ☐ Name change
- ☐ Other _____
- ☐ Control/suffix/acct/plan: _____

Date of event: _____

Reason: _____

Remove or terminate – *Check all that apply.*
- ☐ Remove spouse
- ☐ Remove dependent child
- ☐ Employee withdrawal/ termination
- ☐ Cancel coverage

Effective date: _____

Reason: _____

Continuation of coverage, i.e., COBRA, state
Not all options are available. Contact employer for available options.

Coverage for: ☐ Employee ☐ Dependents

Length of continuation (months):
- ☐ 18 ☐ 36 ☐ Other ____
- ☐ 29 – Attach disability determination from the Social Security Administration

Date of loss of coverage: _____

Date of qualifying event: _____

Continuation of coverage Expiration date: _____

B. Employee information

Social Security number	Last name, first name, middle initial		Home telephone	Work telephone
Employee status ☐ Active ☐ Retired	Home address	Apt. Number	City, state	ZIP code
Employee email address				

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

Check one:

- ☐ Aetna Choice® POS II
- ☐ Aetna HealthFund®
- ☐ Aetna Open Access® Elect Choice
- ☐ Aetna Open Access® Managed Choice
- ☐ Open Choice® PPO
- ☐ Traditional Choice®
- ☐ Other: _____

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. This policy does not include pediatric dental services. Pediatric dental coverage may be purchased as a standalone product. Please seek assistance through Healthcare.gov for pediatric dental plans.

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.***

1	☐ Add ☐ Change ☐ Remove	**Employee name** - Last, first, middle initial	Relation. code **Self**	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /

Social Security number	Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **N/A**	Primary medical office ID number	Current patient **Yes** ☐

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D. Individuals covered *(Continued)* – *List individuals for whom you are enrolling or adding/changing/removing coverage.*
**** Provide details for "Yes*" responses below.***

2	☐ Add ☐ Change ☐ Remove	**Spouse name** - Last, first, 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")	Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary medical office ID number		Current patient **Yes** ☐
3	☐ Add ☐ Change ☐ Remove	**Child name** - Last, first, 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")	Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary medical office ID number		Current patient **Yes** ☐
4	☐ Add ☐ Change ☐ Remove	**Child name** - Last, first, 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")	Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary medical office ID number		Current patient **Yes** ☐
5	☐ Add ☐ Change ☐ Remove	**Child name** - Last, first, 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")	Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary medical office ID number		Current patient **Yes** ☐
6	☐ Add ☐ Change ☐ Remove	**Child name** - Last, first, 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")	Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary medical office ID number		Current patient **Yes** ☐

1. If **yes** to **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 Rx drug coverage** above, provide effective dates, name and policy number of insurance carrier, HMO, 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:

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 an Aetna plan coverage is underwritten or administered by Aetna Life Insurance Company (referred to as "Aetna").
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. 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
4. 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
5. 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.
6. The plan documents will determine the rights and responsibilities of members and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
7. I understand and agree that all our participating providers and vendors are independent contractors. They are not agents or employees of Aetna. We cannot guarantee the availability of any particular provider and the providers in our network may change. Notice of the change shall be provided in accordance with applicable state law.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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 subjects such person to criminal and civil penalties.

Employee signature

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

To the best of my knowledge and belief, 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 Request form.

Employee signature *- required*	***Date*** *(Month/Day/Year)*	***Primary language spoken***
X		

Instructions

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

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

Section A – Type of activity:

- Check box indicating reason for submitting this Enrollment/Change Request.
- Provide Effective date and Date of event 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 must be offered by your employer.

Section D – Individuals covered:

- Check box to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the names of your dependents, 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.**
- If you or your dependents currently have **Other medical coverage**, check the **Yes** box and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and your m**ember identification number** for the insurance plan in the space provided in number 1.
- If you or your dependents have **Other Rx drug coverage**, check the **Yes** box and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and 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 and financially dependent, check **Yes** and provide proof of handicapped status from the attending physician.
- Primary medical office ID number: Locate the office ID number for the primary care physician from the appropriate provider directory or from the online provider directory at **aetna.com**.
- If you are a current patient, please check the **Yes** box under Current patient.

Conditions of enrollment/Misrepresentation – Employee signature: Employee must sign and date the Enrollment/Change Request for new enrollments or coverage changes to be processed.