



Enrollment/Change Request

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(888) 802-3862

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 (IMO only)		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. <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 / domestic partner <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 / domestic partner <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	Home address	Apt. number	City, state	ZIP code
Beneficiary information – Complete only if Aetna Life Insurance coverage is offered by your employer.			Earnings information	
Beneficiary designation – full beneficiary name (First, middle, last) If more than one beneficiary, use Special remarks (section D).			<input type="checkbox"/> Annually \$ _____ <input type="checkbox"/> Weekly \$ _____ <input type="checkbox"/> Insurance amount \$ _____ <input type="checkbox"/> Supplemental Life \$ _____ <input type="checkbox"/> AD&D amount \$ _____	
Beneficiary Social Security number	Birthdate (MMDDYYYY)	Relationship to employee		
Telephone () -	Beneficiary address (number, street, Apt. number, city, state, ZIP code)			

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

<input type="checkbox"/> Aetna Choice® POS II	<input type="checkbox"/> Managed Choice® POS	<input type="checkbox"/> Aexcel®
<input type="checkbox"/> Aetna HealthFund®	<input type="checkbox"/> Open Choice® PPO	<input type="checkbox"/> Aexcel® Plus
<input type="checkbox"/> Aetna Open Access® Managed Choice	<input type="checkbox"/> Traditional Choice®	<input type="checkbox"/> 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. 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. For dependents over age 26 please refer to the instructions on the back of this form.

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

1	(A)dd (C)hange (R)emove	Employee name (last, first, middle initial)	Relationship code Self	Sex (M/F)	Birthdate (MM/DD/YYYY) / /
Social Security number		Prior insurance plan Yes* <input type="checkbox"/>	Other medical coverage Yes* <input type="checkbox"/>	Other Rx drug coverage Yes* <input type="checkbox"/>	Handicapped N/A
Primary medical office ID number (if applicable)		Physician first and last name		Provider ID number	Current patient Yes <input type="checkbox"/>

Continued on next page

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

** Provide details for Yes* responses below.*

2	(A)dd _____ (C)hange _____ (R)emove _____	Spouse / domestic partner name (last, first, middle initial) - Explain difference in last name in Special remarks.	Relationship code	Sex (M/F)	Birthdate (MM/DD/YYYY) / /	
Social Security number		Prior insurance plan Yes* <input type="checkbox"/>	Other medical coverage Yes* <input type="checkbox"/>	Other Rx drug coverage Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	Student Yes <input type="checkbox"/>
Primary medical office ID number (if applicable)		Physician first and last name		Provider ID number	Current patient Yes <input type="checkbox"/>	
3	(A)dd _____ (C)hange _____ (R)emove _____	Child name (last, first, middle initial) - Explain difference in last name in Special remarks)	Relationship code	Sex (M/F)	Birthdate (MM/DD/YYYY) / /	
Social Security number		Prior insurance plan Yes* <input type="checkbox"/>	Other medical coverage Yes* <input type="checkbox"/>	Other Rx drug coverage Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	Student Yes <input type="checkbox"/>
Primary medical office ID number (if applicable)		Physician first and last name		Provider ID number	Current patient Yes <input type="checkbox"/>	
4	(A)dd _____ (C)hange _____ (R)emove _____	Child name (last, first, middle initial) - Explain difference in last name in Special remarks.	Relationship code	Sex (M/F)	Birthdate (MM/DD/YYYY) / /	
Social Security number		Prior insurance plan Yes* <input type="checkbox"/>	Other medical coverage Yes* <input type="checkbox"/>	Other Rx drug coverage Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	Student Yes <input type="checkbox"/>
Primary medical office ID number (if applicable)		Physician first and last name		Provider ID number	Current patient Yes <input type="checkbox"/>	
5	(A)dd _____ (C)hange _____ (R)emove _____	Child name (last, first, middle initial) - Explain difference in last name in Special remarks.	Relationship code	Sex (M/F)	Birthdate (MM/DD/YYYY) / /	
Social Security number		Prior insurance plan Yes* <input type="checkbox"/>	Other medical coverage Yes* <input type="checkbox"/>	Other Rx drug coverage Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	Student Yes <input type="checkbox"/>
Primary medical office ID number (if applicable)		Physician first and last name		Provider ID number	Current patient Yes <input type="checkbox"/>	
6	(A)dd _____ (C)hange _____ (R)emove _____	Child name (last, first, middle initial) - Explain difference in last name in Special remarks.	Relationship code	Sex (M/F)	Birthdate (MM/DD/YYYY) / /	
Social Security number		Prior insurance plan Yes* <input type="checkbox"/>	Other medical coverage Yes* <input type="checkbox"/>	Other Rx drug coverage Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	Student Yes <input type="checkbox"/>
Primary medical office ID number (if applicable)		Physician first and last name		Provider ID number	Current patient Yes <input type="checkbox"/>	
7. 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.						
8. 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.						
9. Does any dependent listed above live at a different address than the employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who and what address?						
Special remarks: 						

Conditions of enrollment

Applicant acknowledgments and agreements

On behalf of myself and the dependents listed in section D, 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. **For life coverages:** Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. I understand that the accelerated death benefit is an optional benefit that must be selected by my employer and may not be available under my life insurance plan.
4. 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 / domestic partner 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 that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
5. 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.
6. 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.

By checking this box you agree to use our member self-service website for all future printed materials and understand you may choose to receive paper documents in the future.

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 on this Enrollment / Change Request form.

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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

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

Instructions

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

Employee – Complete sections **A – D** and the **Employee signature** section.

Section A – Type of activity:

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

Section B – Employee information:

- Complete **all** information in order for your Enrollment / Change Request to be processed.
- Beneficiary designation – Complete **only** if your employer is offering Aetna Life Insurance coverage.

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 listed.
 - Relationship code – Use **ONLY**: H=Husband, W=Wife, S=Son, D=Daughter, Y=Sponsored Male or Domestic Partner, X=Sponsored Female or Domestic Partner. **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 dependent(s) were covered under your employer’s or other **Prior insurance plan** or currently have **Other medical coverage**, check the **Yes** box(es) and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **member identification number** in the space provided in number **7**.
- If you or your dependent(s) 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** in the space provided in number **8**.
 - **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.
- If a dependent is a full time student under the age of 26, check **Yes**. **For information on coverage of dependents over age 26 contact your employer.**
- 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 www.aetna.com.
 - Provide Physician’s first and last name and Provider ID number.
 - If you are a current patient, please check the **Yes** box under Current patient.

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 in this section you agree to use our self-service website for all future printed materials and understand you may choose to receive paper documents in the future.