



# Employee Enrollment/Change Request

## Aetna Health Inc.

**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.**

<p><b>Enrollment</b></p> <input type="checkbox"/> New Enrollee/Subscriber	<p><b>Change – Check all that apply.</b></p> <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"/> Change Plan: _____ <input type="checkbox"/> Control/Suffix/Acct/Plan: _____ <b>Date of Event:</b> ____/____/____ <b>Reason:</b> _____	<p><b>Remove or Terminate – Check all that apply.</b></p> <input type="checkbox"/> Remove Spouse/Domestic Partner <input type="checkbox"/> Remove Dependent Child <input type="checkbox"/> Employee Withdrawal/Termination <b>Effective Date:</b> ____/____/____ <b>Reason:</b> _____	<p><b>Continuation of Coverage, i.e., COBRA, State</b>  <i>Not all options are available. Contact Employer for available options.</i></p> <p><b>Coverage for:</b> <input type="checkbox"/> Employee <input type="checkbox"/> Dependents</p> <p><b>Length of Continuation (months):</b>  <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other ____  <input type="checkbox"/> 29 – Attach disability determination from the Social Security Administration</p> <p><b>Date of Loss of Coverage:</b> ____/____/____  <b>Date of Qualifying Event:</b> ____/____/____  <b>Continuation of Coverage Expiration Date:</b>          ____/____/____</p>
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**B. Employee Information**

Social Security Number	Last Name, First Name, M.I.	Home Telephone
Home Address	Apt. No.	City, State
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 Health Network Option <sup>SM</sup> <input type="checkbox"/> Aetna Health Network Only <sup>SM</sup>	<p><b>Available option with Aetna Health Network Option and Aetna Health Network Only.</b>  <i>Check if applicable.</i></p> <input type="checkbox"/> Aetna HealthFund®	<p><b>Indicate Plan Name</b></p> <hr/> <p><b>Primary Copay</b>  <input type="checkbox"/> \$5      <input type="checkbox"/> \$10  <input type="checkbox"/> \$15      <input type="checkbox"/> Other \$ ____</p>
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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.*

1	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Remove	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"/>	Disabled 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.*

<b>2</b>	(A)dd _____ (C)hange _____ (R)emove _____	Spouse/Domestic Partner 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"/>	Disabled 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"/>
<b>3</b>	(A)dd _____ (C)hange _____ (R)emove _____	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"/>	Disabled 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"/>
<b>4</b>	(A)dd _____ (C)hange _____ (R)emove _____	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"/>	Disabled 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"/>
<b>5</b>	(A)dd _____ (C)hange _____ (R)emove _____	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"/>	Disabled 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"/>
<b>6</b>	(A)dd _____ (C)hange _____ (R)emove _____	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"/>	Disabled 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 <b>Other Medical Coverage</b> above, provide effective dates, name & policy number of insurance carrier, HMO, or other source & your <b>Member Identification Number</b> .								
2. If "Yes" to <b>Other Rx Drug Coverage</b> above, provide effective dates, name & policy number of insurance carrier, HMO, or other source & your <b>Member Identification Number</b> .								
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.)

<b>Employee</b> 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 _____	<b>Child</b> 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 _____
<b>Spouse</b> 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 _____	<b>Child</b> 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 _____
<b>Child</b> 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 _____	<b>Child</b> 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 an Aetna plan, coverage is underwritten or administered by Aetna Health Inc. (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. 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 thirty (30) months. I understand I am entitled to a copy of this authorization upon request and that a photocopy is as valid as the original. This authorization is voluntary. However, I understand that if I refuse to sign this authorization form, my ability to enroll in the plans described above may be affected. I have the right to revoke this authorization in writing to Aetna at any time except to the extent that my information has already been used or disclosed in reliance on this authorization. However, because this information is essential to the administration of the plans, I understand that my revocation of this authorization may result in cancellation of my enrollment in the plans described above.
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® and Aetna Specialty Pharmacy®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, and Aetna Specialty Pharmacy, LLC, are subsidiaries 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. As a condition to HMO benefits, I understand and agree that (with the exception of direct access services and emergency procedures as defined in the plan documents) all services, in order to be covered by the Aetna Health Inc. HMO, 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 prior referral from a participating primary care physician.

### Misrepresentation

**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 may be a crime and subjects such person to criminal and civil penalties.**

If you wish to receive documents electronically, please refer to [www.aetna.com](http://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.

<i>Employee Signature - Required</i>	<i>Date (Month/Day/Year)</i>	<i>Employee E-mail Address</i>	<i>Primary Language Spoken</i>
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 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 *option* in the right column, as applicable.
- 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 disabled and 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](http://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:

- Employee must sign & date the Enrollment/Change Request for new enrollments or coverage changes to be processed.
- Read the Conditions of Enrollment.