



Enrollment/Change Request

Aetna Health Inc.

For Self-Funded Business Only

Control	Suffix	Account	Plan Number
Group Number		Class Code	

Employer Group Information
(To Be Completed by Employer)

Group Name / Employer Name - Full Name of Business or Organization

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

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.

Enrollment

New Enrollee/Subscriber

Effective Date
/ /

Date of Hire
/ /

Change - Check all that apply.

Add Spouse

Add Dependent Child

Name Change

Other

Change Plan

Control/Suffix/Acct/Plan

Date of Event
/ /

Reason

Remove or Terminate - Check all that apply.

Remove Spouse

Remove Dependent Child

Employee Withdrawal/Termination

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 Admin.

Date of Loss of Coverage / /

Date of Qualifying Event / /

Continuation of Coverage Expiration Date / /

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.

PCP Referral Plan QPOS®

Aetna Open Access® PCP Referral Plan

Aetna Choice® POS

Aetna Health Network OptionSM

Aetna Health Network OnlySM

Available options with Aetna Health Network Option and Aetna Health Network Only. Check one.

Aexcel®

Aexcel® Plus

Indicate Plan Name

Primary Copay:

\$5 \$10

\$15 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.

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

* Provide details for "Yes" responses below.

(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Other Medical Coverage	Other Rx Drug Coverage	Handi-capped	Primary Office ID Number (Not required for Aetna Open Access PCP Referral Plan, Aetna Choice POS or Out-of-Network coverages for any plan.)	Current Patient	Dentist Office ID Number (If applicable)	Current Patient	Race/Ethnicity - Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)	
					Yes * <input type="checkbox"/>	Yes * <input type="checkbox"/>	Yes N/A		Yes <input type="checkbox"/>		Yes <input type="checkbox"/>	Code	Other
	Employee	<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>		<input type="checkbox"/>		
	Spouse	<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		
	Child	<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		
	Child	<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		
	Child	<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		

Using the KEY below, please identify the Race/Ethnicity code for each individual.

- KEY:**
- 01 - White
 - 02 - African American or Black
 - 03 - Hispanic or Latino
 - 04 - Asian
 - 05 - Other (Provide race/ethnicity in "Other" column at left)

1. If "Yes" to **Other Medical Coverage** above, provide effective dates, name & policy number of insurance carrier, PCP Referral Plan, or other source and your **Member Identification Number**.

2. If "Yes" to **Other Rx Drug Coverage** above, provide effective dates, name & policy number of insurance carrier, PCP Referral Plan, 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?

Explain the circumstances:

4. If any dependent's last name differs from yours, explain the circumstances.

5. Is your spouse employed? Yes No If "Yes," provide name and address of spouse's employer.

E. Employee Signature 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.

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

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 the reverse side of this Enrollment/Change Request form.

Employee Signature - Required **X**

Date: / / E-Mail Address: _____

Do you have a disability which affects your ability to communicate or read?
 Yes No If "Yes," please indicate the nature of your disability.

What is your primary language?
¿Cuál es su primer idioma?

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.

Instructions

Employer - Complete the **Employer Group Information** at the top of the form.

Employee - Complete Sections A - E.

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.

Section C - Plan Options:

- Select only an option(s) 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 and 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 name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If you or your dependent(s) have **Other Medical Coverage**, check the "Yes" box and provide beginning and ending effective dates, name and policy number of insurance carrier, PCP Referral Plan or other source and 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 and ending effective dates, name and policy number of insurance carrier, PCP Referral Plan 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/Primary Dental Office ID Number: Locate the office ID number for the primary care physician and/or dentist (if applicable) from the appropriate provider directory or from "DocFindSM", Aetna's online provider directory at "www.aetna.com".
 - **NOTE:** You are not required to select a primary care physician for the Aetna Open Access PCP Referral Plan or Aetna Choice POS plan options or Out-of-Network coverages for any plan.
- If you are a current patient, please check the "Yes" box under Current Patient.
- *Optional* - Using the KEY provided, please enter the Race/Ethnicity code for each individual. If your Race/Ethnicity is "Other," print the Race/Ethnicity for each individual in the space provided.

Section E - 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 on the reverse side 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.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, 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 ("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 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.
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, the PCP Referral plan only provides 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. **ATTENTION FEMALE MEMBERS:** Your choice of PCP affects your choice of an OB/GYN. In selecting your PCP, remember that your PCP's network affects your choice of OB/GYN. You have the right to receive services from an OB/GYN without first obtaining a referral from your PCP. However, the OB/GYN from whom you receive services must belong to the same network as your PCP. This is another reason to make certain that your PCP's network includes the specialists - particularly the OB/GYN - and hospitals that you prefer. You are not required to designate an OB/GYN. You may elect to receive your OB/GYN services from your PCP.

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 intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.