Utah Small Group Supplemental Employee Enrollment/Change Form

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Corporate address - Do not send enrollment forms here

A. Employer information

Employer company name	Group number/Control number (if a current Aetna customer)

B. Enrollment information

Effective date	Employee name		Social Security number
Work address		Date of birth	Salary $ ______ ☐ Hourly ☐ Monthly ☐ Weekly
Date of hire	Enrollment – Check all that apply ☐ New group enrollment ☐ New hire ☐ Late enrollee ☐ Rehire / reinstatement ☐ Other ______		

C. Coverage selection

Control/Group number	Suffix	Account	Plan number	Customer code

1. Dental – *Check applicable boxes.* ☐ **Employee** ☐ **Spouse or domestic partner** ☐ **Child**

Non-voluntary plans: ☐ Aetna Dental® Plan - Plan option ______

Voluntary plans: ☐ Aetna Dental® Plan - Plan option ______

Before today, were you covered under this employer's dental plan? ☐ **Yes** ☐ **No**

Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires please see below if applicable:

New Hire selecting a Voluntary Plan **and your Aetna plan is a takeover group**: Were you covered for 12 months under a dental plan within the last 90 days that included both Preventive and Basic coverage? Discount dental and preventive only plans do not apply. ☐ Yes ☐ No

Aetna Life Insurance Company underwrites Aetna dental plans.

Control/Group number	Suffix	Account	Plan number

2. Vision (if applicable) *Check applicable boxes.* ☐ **Employee** ☐ **Spouse or domestic partner** ☐ **Child**

Aetna Vision℠ Preferred ☐ Yes ☐ No

Aetna Life Insurance Company underwrites Aetna vision plans. First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.

D. Changes – *Check all that apply.*

	Name	Date of birth	Social Security number	Date of event	Reason
☐ Add spouse or domestic partner*					
☐ Add child*					
☐ Name change					
☐ Change plan					
☐ Other					

Employee must be enrolled for spouse / domestic partner and dependents to enroll for coverage.

E. Remove or terminate – *Check all that apply.*

	Date of event	Reason
☐ Employee termination		
☐ Remove spouse or domestic partner		
☐ Remove child Name		
☐ Cancel coverage		

Conditions of enrollment

I understand that the following legal entity underwrites the Aetna dental and Aetna vision plans I apply for: Aetna Life Insurance Company.

1. My employer's application determines coverage. I don't have coverage until Aetna approves my employee enrollment form and the employer application. Even if Aetna approves the employer application, any misstatements or omissions may result in denial of future claims. Aetna may rescind or reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Aetna will give at least 30 days advance written notice to any covered person affected by the proposed rescission. If I elect to receive electronic notifications, I will receive this notice in an electronic (email) format.
2. 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 information about mental health and substance use disorder. 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
3. I authorize Aetna to use and disclose such 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
4. I discussed the terms of this authorization with my competent adult dependents. They agreed to these terms. This authorization is valid for 30 months from the signature date. This authorization is valid for the term of the coverage for medical information collected in connection with a medical claim. This authorization is voluntary. But if I don't sign this form, my ability to enroll in the plan may be affected. I have the right to revoke this authorization in writing to Aetna at any time. I can't revoke authorization for information already used or disclosed before I revoked my authorization. I am entitled to receive a copy of this authorization upon request. A photocopy is as valid as the original.
   - The Group Agreement / Group Policy determines the rights and responsibilities of members and will govern in the event they conflict with any:
     - Benefits comparison
     - Summary
     - Other description of the plan
   - Participating physicians, hospitals and other health care providers are independent contractors. They are not Aetna agents or employees. We cannot guarantee the availability of any particular provider. Any provider network is subject to change. We will provide a notice of the change in accordance with applicable state law.
5. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment on this **Utah** Supplemental Employee Enrollment / Change Form. I understand that, if I don't sign this form within 31 days or Aetna does not receive the request within a reasonable time, my eligibility may be affected. I am employed by the employer shown on page 1 at the regular place of business. I am working the required number of hours by this employer to be eligible for coverage. I authorize deductions from my earnings for any contributions required for coverage. I agree to make any necessary payments as required for coverage.

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.

The group policy provides dental and vision benefits only. Review your group policy carefully.

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

Employee signature	*Employee email*	*Date (Month/Day/Year)*
X		