Aetna Vision℠ Preferred Enrollment/Change Request

Aetna Life Insurance Company

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Instructions: *Refer to the instructions on page 3 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.*

Employer group information – To be completed by employer.	**Control**	**Suffix**	**Account**	**Plan number**

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 – D. *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

Subscriber primary language (other than English)
Primer Idioma del suscriptor (que no sea el Ingles)
What is your primary Language? ¿Cuál es su primer idioma?

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

C. Product information

☒ Aetna Vision℠ Preferred
Aetna Vision℠ Preferred may not be available in all states.

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.***

(A)dd **(C)**hange **(R)**emove ___	**1. Employee name** (last, first, middle initial)			Relationship code **Self**	Sex (M/F)
Birthdate (MM/DD/YYYY) / /	**Social Security number**	Other vision coverage **Yes*** ☐	Currently covered by Medicare **Yes*** ☐	Handicapped **N/A**	Student **N/A**

(A)dd **(C)**hange **(R)**emove ___	**2. Spouse 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** (if dependent has no SSN, write "None")	Other vision coverage **Yes*** ☐	Currently covered by Medicare **Yes*** ☐	Handicapped **Yes** ☐	Student **Yes** ☐

Continued on page 2

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

**** Provide details for "Yes*" responses below.*** Attach sheet to list additional children.

(A)dd (C)hange (R)emove	**3. 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** (if dependent has no SSN, write "None")	Other vision coverage **Yes*** ☐	Currently covered by Medicare **Yes*** ☐	Handicapped **Yes** ☐	Student **Yes** ☐

(A)dd (C)hange (R)emove	**4. 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** (if dependent has no SSN, write "None")	Other vision coverage **Yes*** ☐	Currently covered by Medicare **Yes*** ☐	Handicapped **Yes** ☐	Student **Yes** ☐

(A)dd (C)hange (R)emove	**5. 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** (if dependent has no SSN, write "None")	Other vision coverage **Yes*** ☐	Currently covered by Medicare **Yes*** ☐	Handicapped **Yes** ☐	Student **Yes** ☐

(A)dd (C)hange (R)emove	**6. 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** (if dependent has no SSN, write "None")	Other vision coverage **Yes*** ☐	Currently covered by Medicare **Yes*** ☐	Handicapped **Yes** ☐	Student **Yes** ☐

1. If **yes** to **Other vision coverage** and / or **Currently covered by Medicare** above, provide effective dates, name and policy number of insurance carrier, vision plan or other source and your **member identification number**.

2. 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 Vision℠ Preferred plan, coverage is underwritten by Aetna Life Insurance Company (referred to as "Aetna") and that certain claims adjudication and other administrative services are provided by First American Administrators, Inc. (an affiliate of EyeMed Vision Care, LLC) and / or its affiliates.
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, optometrist, 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 a maximum of 24 months. I understand I am entitled to a copy of this authorization upon request and that a photocopy is as valid as the original.

Continued on page 3

Conditions of enrollment *(Continued)*

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®, 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 represent that all information supplied in this form is true and complete to the best of my knowledge and belief. I have read and agree to the Conditions of enrollment and Misrepresentation on this Employee 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.

Employee signature *- required*	***Date (Month/Day/Year)***	***Employee email address (optional)***
X		

Employer verification – To be completed by employer.

Employer signature *- required*	***Title***	***Date (Month/Day/Year)***
X		

Instructions

Employer

- Complete the **Employer group information** at the top of page 1.
- Complete the **Employer verification** which follows the Employee signature above. Employer must sign and date the Enrollment / Change Request for new enrollments or coverage changes to be processed.

Employee – Complete sections A – D. 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(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 – Product information

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.
  - *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 dependent(s) have **Other vision coverage** and / or are **Currently covered by Medicare,** check the **Yes** box(es) and provide beginning and ending effective dates, name and policy number of insurance carrier, vision plan or other source and your **member identification number** for the insurance plan in the space provided in number **1.**
- 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 student, check **Yes**. Refer to your Summary Coverage for plan definitions. Aetna may request that you provide proof from the educational institution.

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