Enrollment/Change Request
Aetna Life Insurance Company

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

TO COMPLY WITH WASHINGTON LAW, WHEREVER THE TERM "SPOUSE" APPEARS, IT WILL BE CONSTRUED TO INCLUDE DOMESTIC PARTNER.

Instructions: *Refer to the instructions 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

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.*
- ☐ 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/Account/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 name		Home telephone ( ) -	Work telephone ( ) -
Employee status ☐ Active ☐ Retired	Home address	Apt. No.	City, state	ZIP code

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

Check one:
- ☐ Aetna Open Choice® PPO
- ☐ Aetna Open Access® Managed Choice (OAMC)
- ☐ Open Access® Managed Choice (OAMC) Aetna Whole Health - Puget Sound
- ☐ Elect Choice® (EPO) – Washington Value Network

Check one if applicable:
- ☐ High Deductible Health Plan (HDHP)
- ☐ Health Reimbursement Arrangement (HRA)

Plan options notes:

_____

_____

_____

_____

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 or removing coverage.***

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

1	☐ Add ☐ Change ☐ Remove	**Employee name** - Last, first, middle initial			Relation. code **Self**	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /
Social Security number		Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **N/A**	Primary medical office ID number		Current patient **Yes** ☐
2	☐ Add ☐ Change ☐ Remove	**Spouse name** - Last, first, middle initial (Explain difference in last name in special remarks.)			Relation. code	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /
Social Security number (if dependent has no SSN, write "None")		Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary medical office ID number		Current patient **Yes** ☐
3	☐ Add ☐ Change ☐ Remove	**Child name** - Last, first, middle initial (Explain difference in last name in special remarks.)			Relation. code	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /
Social Security number (if dependent has no SSN, write "None")		Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary medical office ID number		Current patient **Yes** ☐
4	☐ Add ☐ Change ☐ Remove	**Child name** - Last, first, middle initial (Explain difference in last name in special remarks.)			Relation. code	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /
Social Security number (if dependent has no SSN, write "None")		Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary medical office ID number		Current patient **Yes** ☐
5	☐ Add ☐ Change ☐ Remove	**Child name** - Last, first, middle initial (Explain difference in last name in special remarks.)			Relation. code	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /
Social Security number (if dependent has no SSN, write "None")		Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary medical office ID number		Current patient **Yes** ☐
6	☐ Add ☐ Change ☐ Remove	**Child name** - Last, first, middle initial (Explain difference in last name in special remarks.)			Relation. code	Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /
Social Security number (if dependent has no SSN, write "None")		Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **Yes** ☐	Primary medical office ID number		Current patient **Yes** ☐

1. If **yes** to **Other medical coverage** above, provide effective dates, name and policy number of insurance carrier, HMO, or other source and your **member identification number**.

2. 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**.

3. Does any dependent listed above live at a different address than the employee? ☐ Yes ☐ No If **yes**, who and what address?

Special remarks:

E. 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.)

Employee 1.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child 4.**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____
Spouse 2.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child 5.**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____
Child 3.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child 6.**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

Conditions of enrollment

Applicant acknowledgments and agreements

On behalf of myself and the dependents listed, 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, 151 Farmington Avenue, Hartford, CT 06156 (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. 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.
4. I understand and agree that, with the exception of Aetna Rx Home Delivery® and Aetna Specialty Pharmacy®, all of our contracted providers and vendors are independent contractors and are not agents or employees of Aetna. Aetna Rx Home Delivery, LLC, and Aetna Specialty Pharmacy, LLC, are subsidiaries of Aetna Inc. Aetna cannot guarantee the availability of any particular provider and the providers in Aetna's network may change. Aetna also does not guarantee any results or outcome of a health or dental care service.

Employee signature

If you wish to receive documents electronically, please log in to your secure online portal at www.aetna.com.

I certify 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 on this Employee Enrollment / Change Request form.

Misrepresentation: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Employee signature *- required*	***Date (Month/Day/Year)***	***Employee email address***	***Primary language spoken***
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** below the employee signature on page 3. Employer must sign and date the Enrollment / Change Request for new enrollments or coverage changes to be processed.

Employee – complete sections A – E. 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 – Plan options: Your selection must be offered by your employer.

Section D – Individuals covered:

- Check box 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) 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** 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, HMO 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: Locate the office ID number for the primary care physician from the appropriate provider directory or from Aetna's online provider directory at **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 and date the Enrollment / Change Request for new enrollments or coverage changes to be processed.