



Aetna VisionSM Preferred 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 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 – E. Please print clearly.

Enrollment – Check one. <input type="checkbox"/> New enrollee / subscriber Effective date: / / Date of hire: / / <input type="checkbox"/> Rehire / reinstatement Date of rehire / reinstatement / /	Change – Check all that apply. <input type="checkbox"/> Add spouse <input type="checkbox"/> Add dependent child <input type="checkbox"/> Name change <input type="checkbox"/> Other _____ <input type="checkbox"/> Control / Suffix / Acct / Plan: _____ Date of event: _____ Reason: _____	Remove or terminate – Check all that apply. <input type="checkbox"/> Remove spouse <input type="checkbox"/> Remove dependent child <input type="checkbox"/> Employee withdrawal / termination <input type="checkbox"/> Cancel coverage Effective date: _____ Reason: _____	Continuation of coverage, i.e., COBRA, state <i>Not all options are available. Contact employer for available options.</i> Coverage for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of continuation (months): <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other ____ <input type="checkbox"/> 29 – Attach disability determination from the Social Security Administration Date of loss of coverage: _____ Date of qualifying event: _____ Continuation of coverage expiration date: _____
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B. Employee information

Social Security number	Last name, first name, middle name	Home telephone	Work telephone
Employee status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Home address	Apt. No.	City, state
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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , please indicate the nature of your disability.	

C. Product information

Aetna VisionSM Preferred

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.

(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* <input type="checkbox"/>	Currently covered by Medicare Yes* <input type="checkbox"/>
(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* <input type="checkbox"/>	Currently covered by Medicare Yes* <input type="checkbox"/>

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D. Individuals covered (Continued) – List individuals for whom you are enrolling or adding, changing or 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* <input type="checkbox"/>	Currently covered by Medicare Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	
(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* <input type="checkbox"/>	Currently covered by Medicare Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	
(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* <input type="checkbox"/>	Currently covered by Medicare Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	
(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* <input type="checkbox"/>	Currently covered by Medicare Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	

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:

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. <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 _____	Child 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 _____
Spouse 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 _____	Child 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 _____
Child 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 _____	Child 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 VisionSM 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. 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 participating providers and vendors are independent contractors and are neither insurance producers 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 Aetna's member self-service website for all future printed materials and understand you may choose to receive paper documents in the future.

Employee signature

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 and misrepresentation 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.

<i>Employee signature - required</i>	<i>Date (Month/Day/Year)</i>	<i>Employee email address (optional)</i>
X		

Employer verification - To be completed by employer

<i>Employer signature - required</i>	<i>Title</i>	<i>Date (Month/Day/Year)</i>
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 – 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 – 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=Domestic Partner / Sponsored Male, X=Domestic Partner / 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.

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.