aetna®

Healthy New York Enrollment/Change Request

Aetna Health Inc.
Underwriting, Mailstop U12S
980 Jolly Road, Building 1
Blue Bell, PA 19422
Telephone: 1-866-386-1371

Aetna Health Inc. Use Only

Group Number	Effective Date

1. Employee Information - Please read instructions on reverse side before completing this form. Print clearly.

Last Name, First Name, M.I.	Social Security Number
Home Address (Street Address, Apt. Number, City, State, ZIP Code)	Telephone Numbers Home ( ) - Work ( ) -

2. Type of Activity

	Date of Event	Reason
☐ New Employee		
☐ Add/Remove Dependent		
☐ Name Change		
☐ Withdrawal from Coverage		
☐ Change Primary Office Number		

3. Plan Options

Chose one.

☐ HMO
☐ HMO HDHP

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. Refer to your plan documents or contact your benefits administrator.

4.	No.	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate (MM / DD / YYYY)	Social Security Number	Primary Office No. Physicians' offices must be in the state in which you reside.	Current Patient Yes
Employee	a.			☐ ☐				☐
Spouse	b.			☐ ☐				☐
Children *	c.			☐ ☐				☐
	d.			☐ ☐				☐

* Attach sheet to list additional children.

5. Dependent Information

Do any of the dependents listed in #4 live at another address? ☐ Yes ☐ No

If Yes, who and at what address?

Explain the circumstances:

If any dependent's last name is different from yours, explain the circumstances:

6. Other Health Benefits Coverage - (Please Note: If you are eligible for other benefits coverage, you may not be eligible for this policy.)

Are you employed? ☐ Yes ☐ No	If Yes, please give name and address of your employer.
Are you eligible for other health benefits coverage? (i.e., coverage under your spouse's employer's health benefits coverage, Medicare). ☐ Yes ☐ No	If Yes, please give name and policy number of other insurance carrier or type of coverage. Are other family members eligible for coverage? If Yes, specify. ☐ Yes ☐ No
Are you replacing existing coverage? ☐ Yes ☐ No	If Yes, give name and policy number of other insurance carrier, date of termination, and specify those covered by policy.

7. Pre-Existing Conditions - NOTE: Any pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age, unless enrolled in an Individual Grandfathered plan. Make certain you understand the following:

We will not provide coverage for any services related to a Pre-Existing Condition until you have been continuously covered under this Certificate or by other Creditable Coverage for at least twelve (12) consecutive months. A Pre-Existing condition is any physical or mental condition, disease or ailment for which medical advice, diagnosis, care or treatment was actually recommended or received by a licensed health care provider within the six (6) month period preceding the Enrollment Date. The Enrollment Date is the earlier of your effective date under this Certificate or the first day of any waiting period that your group required you to meet before you were eligible for coverage.

You may receive credit toward the twelve (12) month waiting period for any time you were covered under Creditable Coverage if there was no break in coverage greater than sixty-three (63) days between the termination of the previous coverage and your Enrollment Date under this Certificate. In the case of previous coverage any HMO affiliation period before coverage becomes effective shall be considered as time covered for purposes of providing credit for previous coverage. Creditable Coverage includes a group health plan, health insurance coverage, Medicaid, Medicare, government-sponsored health benefit programs such as CHAMPUS, Peace Corps or Indian Health Service, Federal Employees Health Benefits Program, state health benefits risk pool or coverage under any health insurance plan sponsored by a state, county or other political subdivision.

Pregnancy and genetic information, in the absence of a diagnosis of the condition related to such genetic information, are not Pre-Existing Conditions under this Certificate. In addition, no Pre-Existing Condition waiting period shall apply to an individual who is covered under Creditable Coverage on the thirtieth (30th) day after birth, and no Pre-Existing Condition waiting period shall apply to a child under age eighteen (18) who is adopted or placed for adoption and who is covered under Creditable Coverage on the thirtieth (30th) day after adoption or placement, so long as there is no break in coverage of more than sixty-three (63) days between the end of such Creditable Coverage and the Enrollment Date under this Certificate.

I acknowledge that I have read and understand the above.

Employee Signature _____ Date _____

8. Employee Signature *Employee E-mail Address:*

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this application. I authorize any hospital, physician, or other health care provider to furnish Aetna Health Inc. or its assignee or designee with such medical information about the applicant and of the listed dependents as Aetna Health Inc. or its assignee or designee may require. I acknowledge that I, my spouse (if applicable), and any dependents listed above are not eligible for any group, Medicare, Medicaid or other health benefits coverage.

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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employee Signature _____ Date _____

Enrollment/Change Request Instructions

1. Complete ALL Sections if you are enrolling as a new employee or changing dependent coverage.
2. Complete Sections 1, 2, 4 and 8 if you are changing a provider.
3. Complete Sections 1, 2 and 8 if you are terminating your Aetna Health Inc. coverage.

Section 1 Complete **all** information.

Section 2 Check box(es) indicating reason(s) for submitting form (i.e., new enrollment, coverage change, name change, withdrawal).

Section 3 Select one plan option.

Section 4
- 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 any. Attach sheet to list additional children.
- Provide sex, date of birth, and Social Security Number for each individual listed.
- Contact your employer for information on coverage of dependents over age 26.
- From the appropriate provider directory, locate the 6-digit office number for the primary care physician (required for all members). Indicate office number selection(s) on the form.
- If you are a current patient, please check the "Current Patient" box.

Section 5 This section must be completed for all new enrollments or dependent coverage changes.

Section 6 This section must be completed for all new enrollments or dependent coverage changes.

Section 7 This section must be completed for new enrollments and dependent coverage changes. Application or dependent coverage change will not be processed without signature.

Section 8 Applicant must sign Sections 7 and 8 and date this form for any activity or it will not be processed.

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. Enrollment of myself and of the listed dependents into the plan shall be effective on acceptance by Aetna Health Inc.
2. I am applying for coverage for myself, and/or my spouse, and/or any eligible children up to age 26, and/or any unmarried children who are mentally or physically disabled and who are chiefly dependent upon myself or my spouse for support and maintenance, as listed on the front of this form; and neither my spouse nor children are eligible for group health benefits coverage.
3. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the Contract. Terminations will be processed back to members paid date.
4. As a condition to coverage for most in-network (referred) benefits, I understand and agree that (with the exception of emergency procedures as defined in the Contract) all services, in order to be covered by Aetna Health Inc., must be performed either by a participating primary care physician or by the participating specialist, hospital, or other provider as authorized by prior written referral from a participating primary care physician.
5. I agree to make directly to providers of health care such copayments as are provided for in the Contract.
6. The Contract will determine the rights and responsibilities of member(s) and will govern in the event it conflicts with any benefits comparison, summary, or other description of the HMO Plan.
7. I understand that this coverage will remain in effect regardless of the continued availability of a particular primary care physician or other health care provider.
8. I acknowledge that Aetna Health Inc. participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of Aetna Health Inc.