



# Colorado Small Group Supplemental Employee Enrollment/Change Request (50 or Fewer Eligible Employees)

**Instructions:** You, the employee, must complete this enrollment form along with the Colorado Uniform Employee Application for Small Group Health Benefit Plans (GR-67834-34). You are solely responsible for its accuracy and completeness.

### A. Employer Information

Employer Company Name	Group Number/Control Number (if a current Aetna customer)
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### B. Enrollment Information

Effective Date	Employee Name	Social Security Number
Work Address		
Date of Hire	Enrollment - Check all that apply. <input type="checkbox"/> New Group Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Late Enrollee <input type="checkbox"/> Rehire/Reinstatement <input type="checkbox"/> Other _____	

### C. Coverage Selection – Please print clearly, using black ink.

<b>Control/Group No.</b>  <b>1. Medical - Check applicable boxes*</b> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <b>Check one</b> <input type="checkbox"/> Managed Choice Plan No. _____ Basic Preferred Provider Plan <input type="checkbox"/> CO Basic Limited Mandated Indemnity Plan <input type="checkbox"/> CO Standard Health Mandated Indemnity Plan <input type="checkbox"/> CO Basic Limited Mandated PPO Plan <input type="checkbox"/> CO Standard Mandated Benefit PPO Plan	<b>Control/Group No.</b>  <b>2. Dental - Check applicable boxes*</b> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <b>Check one</b> <b>Standard Plans</b> <input type="checkbox"/> Dental Plan No. _____ <input type="checkbox"/> Freedom-of-Choice <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <input type="checkbox"/> Out-of-State PPO <b>Voluntary Plans</b> <input type="checkbox"/> Dental Plan No. _____ <input type="checkbox"/> Freedom-of-Choice <input type="checkbox"/> DMO® or <input type="checkbox"/> PPO <input type="checkbox"/> Out-of-State PPO Before today, were you covered under this employer's dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Waive Dental - Voluntary <input type="checkbox"/> Covered under another dental plan <input type="checkbox"/> Other _____	<b>Control/Group No.</b>  <b>3. Life - Check applicable boxes*</b> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <b>Check if applicable</b> <input type="checkbox"/> Basic Life/AD&D Ultra <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Life & Disability Packaged Plan Beneficiary Designation – Full Name (First Middle, Last) Beneficiary Social Security No.    Relationship to Employee
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Did you have prior dental coverage?     Yes     No    If "Yes," provide the following:

Name of Covered Individual	Carrier Name	Group Number	Start Date	Term Date

### D. Changes – Check all that apply.

	Name	Date of Birth	Social Security No.	Date of Event	Reason
<input type="checkbox"/>	Add Spouse*				
<input type="checkbox"/>	Add Child*				
<input type="checkbox"/>	Name Change				
<input type="checkbox"/>	Change Plan				
<input type="checkbox"/>	Other				

*\*Employee must be enrolled for spouse/dependent(s) to enroll for coverage.*

### E. Remove or Terminate – Check all that apply.

	Date of Event	Reason
<input type="checkbox"/>	Employee Termination	_____
<input type="checkbox"/>	Remove Spouse	_____
<input type="checkbox"/>	Remove Child: Name _____	_____
<input type="checkbox"/>	Cancel Coverage	_____

**F. COBRA or State Continuation – Check all that apply.**

<input type="checkbox"/> Employee	<input type="checkbox"/> Dependent Name: _____	<input type="checkbox"/> Dependent Name: _____
<input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation	<input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation	<input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation
Qualifying Event: _____	Qualifying Event: _____	Qualifying Event: _____
Start Date: _____ Stop Date: _____	Start Date: _____ Stop Date: _____	Start Date: _____ Stop Date: _____

**Conditions of Enrollment**

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

- I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
  - Aetna PPO Plan, Aetna Traditional Choice Plan, Basic PPO, Standard PPO, Basic Indemnity and Standard Indemnity: Aetna Life Insurance Company.
  - Life, Accidental Death & Dismemberment, disability, dental and all other coverages: Aetna Life Insurance Company.
- I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee and employer applications have been accepted and approved by Aetna. Even if this enrollment form is approved, any misstatements or omissions may result in future claims being denied and the policy or my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes.  
**For life and disability coverages:** I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the benefit plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent.
- I understand and agree that this **Colorado** Small Group (50 or Fewer Eligible Employees) Employee Enrollment/Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") including pharmacies or pharmacy database benefit managers to give to Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this enrollment 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. This authorization will remain valid for the term of the coverage and for so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
- 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.
- 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.
- I understand and agree that, with certain exceptions described in the plan documents, DMO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, primary care dentist, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.

**COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2 - 50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.**

**Misrepresentation**

- It is unlawful 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.

**Attention Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.**

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **Colorado** Small Group Employee Enrollment/Change Request (50 or Fewer Eligible Employees). I understand that, in the event I fail to sign this form within 31 days of my eligibility date or for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my and my dependents' eligibility may be affected. I am employed by the employer shown on Page 1, and I am working full time at least 24 hours per week for this employer at the regular place of business.

<b>Employee Signature</b> X	<b>Employee E-mail Address (optional)</b>	<b>Date (Month/Day/Year)</b>
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