



# Enrollment/Change Request

## Aetna Health Inc.

<b>Employer Group Information - To Be Completed by Employer:</b>	<b>Group Name</b>	<b>Group Number</b>	<b>Class Code</b>
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**A. Type of Activity - Employee Completes Sections A - E. Please Print Clearly.**

<p><i>Instructions: Refer to the instructions on the back before completing this form. You, the employee, 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.</i></p>	<p><b>Enrollment</b></p> <p><input type="checkbox"/> New Enrollee/Subscriber</p> <p style="text-align: center;"><b>Effective Date</b></p> <p style="text-align: center;">/ /</p> <p style="text-align: center;"><b>Date of Hire</b></p> <p style="text-align: center;">/ /</p>	<p><b>Change - Check all that apply.</b></p> <p><input type="checkbox"/> Add Spouse</p> <p><input type="checkbox"/> Add Dependent Child</p> <p><input type="checkbox"/> Name Change</p> <p><input type="checkbox"/> Change Plan</p> <p><input type="checkbox"/> Other</p> <p style="text-align: center;"><b>Date of Event</b></p> <p style="text-align: center;">/ /</p> <p style="text-align: center;"><b>Reason</b></p> <p style="text-align: center;">_____</p>	<p><b>Remove or Terminate - Check all that apply.</b></p> <p><input type="checkbox"/> Remove Spouse</p> <p><input type="checkbox"/> Remove Dependent Child</p> <p><input type="checkbox"/> Employee Withdrawal/Termination</p> <p style="text-align: center;"><b>Effective Date</b></p> <p style="text-align: center;">/ /</p> <p style="text-align: center;"><b>Reason</b></p> <p style="text-align: center;">_____</p>	<p><b>Continuation of Coverage, i.e., COBRA, State - Not all options are available. Contact Employer for available options.</b></p> <p>Coverage For: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents</p> <p>Length of Continuation: <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> 29 - Attach disability determination from the Social Security Admin.</p> <p>Date of Loss of Coverage: / /</p> <p>Date of Qualifying Event: / /</p>
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**B. Employee Information**

Social Security Number	Last Name, First Name, M.I.	Home Telephone ( )
Home Address	Apt. No. City, State	ZIP Code
Employer Name	Work Telephone ( )	
Work Address	City, State	ZIP Code

**C. Plan Option - Your selection must be offered by your employer.**

<p><b>Check One:</b></p> <p><input type="checkbox"/> HMO    <input type="checkbox"/> QPOS®    <input type="checkbox"/> USAccess®</p> <p><input type="checkbox"/> Aetna Open Access™ HMO</p> <p><input type="checkbox"/> Aetna Choice™ POS</p>	<p><b>Indicate Plan Name</b></p> <hr/> <p><b>Primary Copay:</b></p> <p><input type="checkbox"/> \$5    <input type="checkbox"/> \$10</p> <p><input type="checkbox"/> \$15    <input type="checkbox"/> Other \$_____</p>
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**D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children.**

(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex		Birthdate			Social Security Number	Other Health Coverage	Other Rx Drug Coverage	Primary Office ID Number <small>(Not required for Aetna Open Access HMO or Aetna Choice POS)</small>	Current Patient	Dentist Office ID Number <small>(If applicable)</small>	Current Patient	Race/Ethnicity - Optional <small>(This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)</small>					
		M	F	MM	DD	YYYY								<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	
Employee		<input type="checkbox"/>	<input type="checkbox"/>	/	/			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse		<input type="checkbox"/>	<input type="checkbox"/>	/	/			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child		<input type="checkbox"/>	<input type="checkbox"/>	/	/			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child		<input type="checkbox"/>	<input type="checkbox"/>	/	/			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child		<input type="checkbox"/>	<input type="checkbox"/>	/	/			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does any dependent listed in above live at a different address than the Employee? If "Yes," who and what address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explain the circumstances.	If any dependent's last name differs from yours, explain the circumstances.
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Is your Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide name and address of spouse's employer.	If "Yes" to Other Health Coverage and/or Other Rx Drug Coverage above, provide name & policy number of insurance carrier, HMO, or other source.
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**E. Employee Signature**

*If you have questions concerning the benefits provided by or excluded under this Agreement, contact a Member Services representative at 1-800-323-9930 before signing this form.*

<p>I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this application.</p>	<p><b>Employee Signature - Required</b></p> <p style="text-align: center;"><b>X</b></p> <p>Date / /    E-Mail Address _____</p>	<p>Do you have a disability which affects your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please indicate the nature of your disability.</p>	<p>What is your primary language? ¿Cuál es su primer idioma?</p>
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**F. Employer Verification - To Be Completed by Employer**

<p><b>Employer Signature - Required</b></p> <p style="text-align: center;"><b>X</b></p> <p>Title _____ Date / /</p>
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**Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Aetna prior to visiting a specialist or admission to a hospital.**

## Instructions

### Employer

- Complete the **Employer Group Information** at the top of the form.
- Complete **Section F - Employer Verification** in the lower right corner of the form.
  - Employer must complete this section for all new enrollments or coverage changes.
  - Employer must sign and date the Enrollment/Change Request in order for it to be processed.

### Employee - Complete Sections A - E.

#### Section A - Type of Activity:

Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.

#### Section B - Employee Information:

Complete **all** information in order for your Enrollment/Change Request to be processed.

#### Section C - Plan Option:

- Select only an option offered by your employer.
- Check one Plan Option box, indicate Plan Option Name (where applicable) and check *one* Primary Copay.

#### 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 name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If you or your dependent(s) have other Health or Rx Drug Coverage, check the "Yes" box(es) and provide name and policy number of insurance carrier, HMO or other source in the space provided.
- From the appropriate provider directory, locate the **6-digit** office ID number for the primary care physician and/or dentist (if applicable). Indicate office ID number selection(s) on the form.  
**Note:** You are not required to select a primary care physician for the Aetna Open Access HMO or Aetna Choice POS plan options.
- If you are a current patient, please check the "Yes" box under Current Patient.
- *Optional* - Indicate the Race/Ethnicity for yourself and your dependents by checking the appropriate box(es). If your Race/Ethnicity is other than the selections listed, please check the "Other" box and print the Race/Ethnicity for yourself and your dependents in the space provided.

#### Section E - Employee Signature:

- Complete this section for all new enrollments or coverage changes.
- Employee must sign and date the Enrollment/Change Request in order for it to be processed.

#### Section F - Employer Verification:

- Employer must complete this section for all new enrollments or coverage changes.
- Employer must sign and date the Enrollment/Change Request in order for it to 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. I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
  - HMO: Aetna Health Inc.
  - QPOS/Aetna Choice POS/USAccess: Aetna Health Inc. and/or Corporate Health Insurance Company.
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, 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 the term of the coverage and 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.
4. The plan documents (Schedule of Benefits, Group Agreement, Certificate of Coverage, Group Policy, Group Insurance Certificate) 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.
6. I understand and agree that, with certain exceptions described in the plan documents, HMO 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, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.

### Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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 subjects such person to criminal and civil penalties.