



Enrollment/Change Request

Aetna Life Insurance Company

Employer Group Information: (To Be Completed by Employer)	Employer Name - Full Name of Business or Organization	Control	Suffix	Account	Plan Number
	Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	Group Number (IMO Only)		Customer Code (Optional)	

A. Type of Activity - Employee Completes Sections A - E. Please Print Clearly.

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.	Enrollment - Check one. <input type="checkbox"/> New Enrollee/Subscriber <input type="checkbox"/> 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	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	Continuation of Coverage, i.e., COBRA, State - Not all options are available. Contact Employer for available options. Coverage For: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation: <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____ <input type="checkbox"/> 29 - Attach disability determination from the Social Security Admin. Date of Loss of Coverage: ____/____/____ Date of Qualifying Event: ____/____/____
	Effective Date: ____/____/____	Date of Rehire/Reinstatement: ____/____/____	Date of Event: ____/____/____	Effective Date: ____/____/____
	Date of Hire: ____/____/____	Reason: _____	Reason: _____	

B. Employee Information

Social Security Number	Last Name, First Name, M.I.	Home Telephone () () ()	Work Telephone () () ()
Employee Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Home Address	Apt. No.	City, State
Beneficiary Designation - Full Beneficiary Name (First, Middle, Last) If more than one beneficiary, use Special Remarks (Section D).		Social Security Number of Beneficiary	Relationship to Employee
Earnings		Insurance Amount \$ _____	Supplemental Life \$ _____
Annually \$ _____		AD&D Amount \$ _____	
Weekly \$ _____			

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

Check One:

<input type="checkbox"/> Aetna Choice™ POS II	<input type="checkbox"/> Managed Choice® POS
<input type="checkbox"/> Aetna HealthFund™	<input type="checkbox"/> Open Choice® PPO
<input type="checkbox"/> Aetna Open Access™ Elect Choice	<input type="checkbox"/> Traditional Choice®
<input type="checkbox"/> Aetna Open Access™ Managed Choice	<input type="checkbox"/> Aexcel SM
<input type="checkbox"/> Elect Choice® EPO	<input type="checkbox"/> Aexcel SM Plus
	<input type="checkbox"/> Other _____

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage.

Attach sheet to list additional children.

Check this box if you are refusing coverage for your dependents.

(A)dd (C)hange (R)emove	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks.)	Relat. Code	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Prior Insur. Plan	Other Medical Coverage	Other Rx Drug Coverage	Handi-capped	Student	Primary Medical Office ID Number	Current Patient	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.)
		Self	<input type="checkbox"/> <input type="checkbox"/>	/ /		Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/> N/A	Yes <input type="checkbox"/> N/A		Yes <input type="checkbox"/>	<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 _____
			<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"/> 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 _____
			<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"/> 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 _____
			<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"/> 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 _____
			<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"/> 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 _____

If "Yes" to Prior Insurance Plan, Other Medical Coverage and/or Other Rx Drug Coverage above, provide effective date, name & policy number of insurance carrier, HMO, or other source.

Special Remarks

Does any dependent listed in above live at a different address than the Employee? If "Yes," who and what address?
 Yes No

E. Employee Signature

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 this application.	Employee Signature - Required X	Primary Language Spoken
	Date: ____/____/____ E-Mail Address: _____	

F. Employer Verification - To Be Completed by Employer

Employer Signature X	Date: ____/____/____
Title: _____	

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. 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.
- Beneficiary Designation - Complete only if your employer is offering Aetna Life Insurance coverage.

Section C - Plan Option:

- Select only an option offered by your employer.

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.
 - 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) were covered under your employer's or other prior insurance plan, check the "Yes" box(es) and provide name and policy number of insurance carrier, HMO or other source in the space provided.
- 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.
- If a dependent is Handicapped and financially dependent, check "Yes" and provide proof of handicapped status from the attending physician.
- If a dependent is Student, check "Yes". Refer to your Summary Coverage for plan definitions. (Defined as: Unmarried dependent child age 19 or older, regularly attends school and depends solely on the enrollee for support. Aetna may request that you provide proof from the educational institution.)
- Primary Medical Office ID Number - Locate the office ID number for the primary care physician from the appropriate provider directory or from "DocFind[®]", Aetna's online provider directory at "www.aetna.com".
- 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 an Aetna plan coverage is provided by Aetna Life Insurance Company (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. 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 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.

Misrepresentation

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 may have violated state law.

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

Attention Kentucky and Pennsylvania Residents: 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 subjects such person to criminal and civil penalties.