



# Enrollment/Change Request

Aetna Health Inc.

Control	Suffix	Account	Plan Number
Group Number		Class Code	

**Employer Group Information (To Be Completed by Employer)**  
 Group Name / Employer Name - Full Name of Business or Organization

**Continuation of Coverage, i.e., COBRA, State - Not all options are available. Contact Employer for available options.**  
 Coverage For:  Employee  Dependents  
 Length of Continuation (months):  18  36  Other \_\_\_\_\_  
 29 - Attach disability determination from the Social Security Admin.  
 Date of Loss of Coverage \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Date of Qualifying Event \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Continuation of Coverage Expiration Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**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 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.

<b>Enrollment</b> <input type="checkbox"/> New Enrollee/Subscriber <b>Effective Date</b> / /  <b>Date of Hire</b> / /	<b>Change - Check all that apply.</b> <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Other <input type="checkbox"/> Change Plan _____ <input type="checkbox"/> Control/Suffix/Acct/Plan _____	<b>Date of Event</b> / /  <b>Reason</b> _____
		<b>Remove or Terminate - Check all that apply.</b> <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Remove Dependent Child <input type="checkbox"/> Employee Withdrawal/Termination

<b>Effective Date</b> / /  <b>Reason</b> _____
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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 Options - Your selection(s) must be offered by your employer.**

<input type="checkbox"/> HMO <input type="checkbox"/> QPOS® <input type="checkbox"/> Aetna Open Access™ HMO <input type="checkbox"/> Aetna Choice™ POS <input type="checkbox"/> AHF Choice POS <input type="checkbox"/> Aetna Health Network Option™ <input type="checkbox"/> Aetna Health Network Only™	<b>Available options with Aetna Health Network Option and Aetna Health Network Only. Check all that apply.</b> <input type="checkbox"/> Aetna HealthFund™ <input type="checkbox"/> Aexcel® <input type="checkbox"/> Aexcel® Plus	<b>Indicate Plan Name</b>  <b>Primary Copay:</b> <input type="checkbox"/> \$5 <input type="checkbox"/> \$10 <input type="checkbox"/> \$15 <input type="checkbox"/> Other \$ _____
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**D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage.**

\* Provide details for "Yes" responses below.

Attach sheet to list additional children. Attach proof if full-time college student.

(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Other Medical Coverage	Other Rx Drug Coverage	Handi-capped	Student	Primary Medical Office ID Number	Current Patient	Dentist Office ID Number (If applicable)	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.)
	Employee	<input type="checkbox"/> <input type="checkbox"/>	/ /		Yes * <input type="checkbox"/>	Yes * <input type="checkbox"/>	Yes N/A	Yes N/A		Yes <input type="checkbox"/>		Yes <input type="checkbox"/>	Code Other
	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"/>	
	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"/>	
	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"/>	
	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"/>	

1. If "Yes" to <b>Other Medical Coverage</b> above, provide effective dates, name & policy number of insurance carrier, HMO, or other source and your <b>Member Identification Number</b> .	3. Does any dependent listed above live at a different address than the employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," who and what address?  Explain the circumstances:	4. If any dependent's last name differs from yours, explain the circumstances.  5. Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide name and address of spouse's employer.
2. If "Yes" to <b>Other Rx Drug Coverage</b> above, provide effective dates, name & policy number of insurance carrier, HMO, or other source and your <b>Member Identification Number</b> .		

**E. Employee Signature**

By checking this box you agree to use Aetna Navigator, Aetna's member self-service website, for all future printed materials and understand you may choose to receive paper documents in the future.

**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.**

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment on the reverse side of this Enrollment/Change Request form.	Employee Signature - Required <b>X</b>	Primary Language Spoken _____
	Date / / E-Mail Address _____	

**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.

**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.

### Section C - Plan Options:

- Select only an option(s) offered by your employer.
- Check *one* Plan Option box in the left column. If you have selected the Aetna Health Network Option or Aetna Health Network Only, check *all that apply* in the right column.
- Where applicable, indicate Plan Option Name 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 Medical Coverage**, check the "Yes" box and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **Member Identification Number** for the insurance plan in the space provided in Number 1.
- If you or your dependent(s) have **Other Rx Drug Coverage**, check the "Yes" box and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **Member Identification Number** for the insurance plan in the space provided in Number 2.
  - **NOTE:** In some instances your medical carrier will differ from your Rx drug carrier.
- If a dependent is Handicapped and financially dependent, check "Yes" and provide proof of handicapped status from the attending physician.
- If a dependent is a full-time Student, check "Yes". You **must** attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits).
- Primary Medical Office ID Number/Primary Dental Office ID Number: Locate the office ID number for the primary care physician and/or dentist (if applicable) from the appropriate provider directory or from "DocFind<sup>®</sup>", Aetna's online provider directory at "www.aetna.com".
- If you are a current patient, please check the "Yes" box under Current Patient.
- *Optional* - Using the KEY provided, please enter the Race/Ethnicity code for each individual. If your Race/Ethnicity is "Other," print the Race/Ethnicity for each individual 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.
- By checking the box on the reverse side you agree to use Aetna Navigator, Aetna's member self-service website, for all future printed materials and understand you may choose to receive paper documents in the future.

## 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 underwritten or administered by the following entities (collectively referred to as "Aetna"):
  - HMO / Aetna Health Network Only: Aetna Health Inc.
  - QPOS / Aetna Choice POS / Aetna Health Network Option: Aetna Health Inc., Corporate Health Insurance Company, and/or Aetna Life 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.

**Attention Massachusetts Residents:** 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 may subject such person to criminal and civil penalties.

**Attention Tennessee Residents:** 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.