Washington Employee Enrollment/Change Form
(For groups with 1 to 50 employees)

WHEREVER THE TERM "SPOUSE" APPEARS
IT WILL BE CONSTRUED TO INCLUDE REGISTERED AND NON REGISTERED DOMESTIC PARTNER.

Aetna PPO and Indemnity plans are underwritten by Aetna Life Insurance Company.

INSTRUCTIONS: You must complete this enrollment form in full. If you do not, we will return it to you, and that can delay its processing. You alone are responsible for its accuracy and completeness. If you are declining coverage, you must complete Section B. Please use only black ink to complete this form.

Group number

Aetna member ID number (if available)

Company name:

Effective date / Date of hire / Benefit waiting period*			
Benefit waiting period* ☐ Class 1 ☐ Class 2 * Only required when your employer has 2 benefit waiting periods	☐ New hire ☐ Rehire / reinstatement ☐ New group enrollment ☐ Late enrollment ☐ Waiver ☐ Open enrollment ☐ Loss of coverage	☐ Add spouse ☐ Add domestic partner ☐ Add dependent child ☐ Change of coverage ☐ Name change	☐ Employee termination date: _____ ☐ Remove spouse ☐ Remove domestic partner ☐ Remove dependent child ☐ Cancel coverage ☐ Other _____

☐ COBRA for: ☐ Employee ☐ Dependent Length of continuation: ☐ 18 months ☐ 36 months ☐ Other ____
Qualifying event _____ Original qualifying event date _____ Loss of coverage date _____

A. Employee information - *You must complete this section.*

Social Security number	Last name, first name, middle initial		Job title
Home address	Apt. number	City, state	ZIP code
Work address		City, state	ZIP code
Home telephone ( ) -	Work telephone ( ) -	Primary language spoken (optional)	Number of dependents, including spouse or domestic partner, enrolling for medical coverage
Number of hours worked a week	Check one ☐ Full time ☐ Part time ☐ 1099 ☐ Retired ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union		

B. Declining coverage - *To be completed if medical coverage is declined or refused by an eligible employee and / or their eligible family members.*

Medical coverage declined for: ☐ Myself ☐ Spouse ☐ Dependents		
Reason for declining coverage		
☐ Individual coverage – On Exchange	☐ Medicaid	☐ Insurance through another job
☐ Individual coverage – Off Exchange	☐ Another group plan provided by my employer	☐ Individual coverage
☐ Spousal group coverage	☐ COBRA coverage	☐ Retiree coverage
☐ Parental coverage	☐ TRICARE Military coverage	☐ I have no other coverage
☐ Medicare	☐ VA coverage	☐ Other _____
I acknowledge I have been given the right to apply for this coverage; however, I am electing not to enroll. By declining this group coverage I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. I and/or my dependents have this decision of my/their own accord, with no pressure from my employer, my employer's agent or the insurance carrier.		
Please sign here ONLY if you are declining coverage for yourself or dependent(s). X Employee signature		*Date (Month/Day/Year)*
Please PRINT employee name:		

C. Medical coverage selection – *Please print clearly.*

Control/Group number	Suffix	Account	Plan number

Medical ☐ Yes ☐ No *Check applicable boxes.* ☐ Employee ☐ Spouse ☐ Child(ren)

Select plan option and then check the box for the network you choose. You are able to choose an AWH PPO network based on your home or work ZIP code.

PLAN OPTIONS	NETWORKS-Aetna and Aetna Whole Health (AWH)			
	Aetna PPO Statewide	AWH Polyclinic PPO King County	AWH Providence/ Swedish PPO King County and Snohomish County	AWH Rainier Health PPO King County and Pierce County
WA Gold PPO 250 80/50	☐	☐	☐	☐
WA Gold PPO 500 80/50	☐	☐	☐	☐
WA Gold PPO 1000 80/50	☐	☐	☐	☐
WA Silver PPO 1350 80/50	☐	☐	☐	☐
WA Silver PPO 1500 80/50	☐	☐	☐	☐
WA Silver PPO 1750 80/50	☐	☐	☐	☐
WA Silver PPO 2000 80/50	☐	☐	☐	☐
WA Silver PPO 3000 80/50	☐	☐	☐	☐
WA Bronze PPO 7150 100/50	☐	☐	☐	☐
WA Bronze PPO Saver 5250 70/50	☐	☐	☐	☐
WA Bronze PPO Saver 6350 70/50	☐	☐	☐	☐
WA Bronze PPO 4000 Copay	☐	☐	☐	☐
WA Silver PPO 1500 80/50 HSA-T	☐	☐	☐	☐
WA Silver PPO 2000 80/50 HSA-T	☐	☐	☐	☐
WA Silver PPO 2600 80/50 HSA-E	☐	☐	☐	☐
WA Bronze PPO 4900 60/50 HSA-E	☐	☐	☐	☐
WA Bronze PPO 5500 80/50 HSA-E	☐	☐	☐	☐
WA Bronze PPO 5500 60/70/50 HSA-E	☐	☐	☐	☐
WA Silver Indemnity 1700 80 (only available if PPO networks are not available)	☐ (non-network)	N/A	N/A	N/A

D. Individuals covered – *List individuals for whom you are enrolling or adding, changing or removing coverage. Add more sheets if needed and staple to the back of this application.*

NOTE FOR MEDICAL COVERAGE: While the Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Please refer to your plan documents or contact your benefits administrator.

1	☐ Add ☐ Change ☐ Remove	Employee name (Last, first, middle initial)	Sex (M/F)
Birthdate (MM/DD/YYYY) / /		Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated	
2	☐ Add ☐ Change ☐ Remove	Name (Last, first, middle initial) ☐ Spouse ☐ Registered domestic partner ☐ Non registered domestic partner*	Sex (M/F) / Social Security number
Birthdate (MM/DD/YYYY) / /			
3	☐ Add ☐ Change ☐ Remove	Name (Last, first, middle initial) ☐ Child ☐ Stepchild ☐ Other _____	Sex (M/F) / Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated ☐ Yes ☐ No	
4	☐ Add ☐ Change ☐ Remove	Name (Last, first, middle initial) ☐ Child ☐ Stepchild ☐ Other _____	Sex (M/F) / Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated ☐ Yes ☐ No	
5	☐ Add ☐ Change ☐ Remove	Name (Last, first, middle initial) ☐ Child ☐ Stepchild ☐ Other _____	Sex (M/F) / Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated ☐ Yes ☐ No	
6	☐ Add ☐ Change ☐ Remove	Name (Last, first, middle initial) ☐ Child ☐ Stepchild ☐ Other _____	Sex (M/F) / Social Security number
Birthdate (MM/DD/YYYY) / /		Incapacitated ☐ Yes ☐ No	

*Non registered domestic partner must complete Affidavit of Domestic Partnership.

E. Dependent information

List any dependent in Section D living at another address.

Name	Address

F. Coordination of benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No

If yes, will the Aetna coverage you're applying for replace the coverage you have now? ☐ Yes ☐ No

Name of person	Carrier name	Name of person	Carrier name

Conditions of enrollment

On behalf of myself and the dependents listed, 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 understand and agree that my employer's application will determine coverage and that there is no coverage until Aetna has approved both my employee enrollment form and the employer applications.
3. Authorizations signed for the purpose of collecting information in connection with this enrollment form for an insurance policy, a policy reinstatement or a request for a change in policy benefits shall remain valid for thirty (30) months from the date signed. Authorizations signed for the purpose of collecting information in connection with a claim for benefits shall remain valid for the term of this coverage or for so long as allowed by law. The information, as well as other personal or privileged information, subsequently collected by the insurance institution or insurance producer may, in certain circumstances, be disclosed to third parties without authorization. A right of access and correction exists with respect to all personal information collected. Further disclosures required by Washington law will be furnished to the policyholder upon request. Personal information may be collected from persons other than the individual or individuals proposed for coverage. This authorization is voluntary. However, I understand that if I refuse to sign this authorization form, my ability to enroll in the medical plans described above may be affected. I have the right to revoke this authorization in writing to Aetna at any time except to the extent that my information has already been used or disclosed in reliance on this authorization. However, because this information is essential to the administration of the plans, I understand that my revocation of this authorization may result in cancellation of my enrollment in the medical plans described above.
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 providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

I represent that all information supplied in this form is true and complete. I have read and agree to the conditions of enrollment on this Employee Enrollment / Change Form.

I understand that in the event I fail to sign this form within 31 days (or 60 days if my dependent or I qualify for a special enrollment period) after the above transaction request or for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my eligibility and my dependents' eligibility may be affected.

I am employed by the employer shown on page 1. I am working full time or at least 20 hours or more a week for this employer at the regular place of business. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments required for coverage.

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.

If you wish to receive documents online, please visit your secure member account at aetna.com/individuals-families/aetna-navigator.html

Please sign here ONLY if you are enrolling in coverage for yourself and/or dependent(s). *Employee signature (required)*	*Employee email*	*Date (Month/Day/Year)*