Washington Small Group Employee Enrollment/Change Form

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

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	☐ 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 _____
Date of hire			

☐ **COBRA** or ☐ State continuation 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. Please print clearly.*

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/cell 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 ☐ 1099 ☐ Seasonal ☐ COBRA ☐ Part time ☐ Retired ☐ Temporary ☐ Union			Employee email

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

Medical coverage declined for: ☐ Myself ☐ Spouse ☐ Dependents
Dental coverage declined for: ☐ Myself ☐ Spouse ☐ Dependents
Vision 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 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 made this decision of my/their own accord, with no pressure from my employer, my employer's agent or the insurance carrier.

Please sign here <u>ONLY</u> if you are declining coverage for yourself or dependents.	***Date (Month/Day/Year)***
X Employee signature	

Please PRINT employee name:

C. Coverage selection

Control/group number	Suffix	Account	Plan number

1. Medical ☐ Yes ☐ No *Check applicable boxes.* ☐ Employee ☐ Spouse ☐ Children

Select a plan option.

☐ WA Gold PPO 500 80/50
☐ WA Gold PPO 1000 80/50
☐ WA Silver PPO 2000 80/50
☐ WA Silver PPO 2400 70/50
☐ WA Silver PPO 3000 80/50
☐ WA Silver PPO 4000 80/50
☐ WA Bronze PPO 6200 70/50
☐ WA Bronze PPO 6850 100/50 Copay Plan
☐ WA Silver PPO 2450 80/50 HSA-T
☐ WA Silver PPO 3000 80/50 HSA-E
☐ WA Silver PPO 5000 80/50 HSA-E
☐ WA Bronze PPO 6250 70/50 HSA-E

Aetna Life Insurance Company underwrites Aetna PPO plans.

Control/group number	Suffix	Account	Plan number

2. Dental ☐ Yes ☐ No *To enroll, enter the plan number and name below.*

Non-voluntary plans – Plan number _____ Plan name _____

If FOC, choose: ☐ DMO® *or* ☐ PPO

Voluntary plans – Plan number _____ Plan name _____

If FOC, choose: ☐ DMO® *or* ☐ PPO

Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires please see below if applicable:

New Hire selecting a Voluntary plan **and your Aetna plan is a takeover group**: Were you covered for 12 months under a dental plan within the last 90 days that included both Preventive and Basic coverage? Discount dental and preventive only plans do not apply. ☐ Yes ☐ No

Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®.

Aetna Life Insurance Company underwrites Aetna dental plans.

Control/group number	Suffix	Account	Plan number

3. Aetna Vision℠ Preferred ☐ Yes ☐ No

Aetna Life Insurance Company underwrites Aetna vision plans. First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.

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 ☐ Widow ☐ Legally separated		Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision

2	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Spouse** ☐ **Domestic partner**	Sex (M/F)	**Social Security number**
Birthdate (MM/DD/YYYY) / /		Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		

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	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		

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D. Individuals covered *(Continued)*

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	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		
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	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		
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	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		

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

I agree to or with the following:

1. Aetna Life Insurance Company (referred to as "Aetna") underwrites Aetna PPO plans, Aetna dental plans and Aetna vision plans. First American Administrators, Inc. provides certain claims adjudication services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.
2. My employer's application determines coverage. I don't have coverage until Aetna approves 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.

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Conditions of enrollment *(Continued)*

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 if I don't sign this form within 60 days or Aetna does not receive the request within a reasonable time, my 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. 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.

To receive documents online, please visit your secure member account at aetna.com.

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