aetna®

# Enrollment/Change Request
## Aetna Life Insurance Company

**Aetna Life Insurance Company**
151 Farmington Avenue
Hartford, CT 06156

**TO COMPLY WITH WASHINGTON LAW, WHEREVER THE TERM "SPOUSE" APPEARS, IT WILL BE CONSTRUED TO INCLUDE DOMESTIC PARTNER.**

***Instructions:*** *Refer to the instructions 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.*

| Control | Suffix | Account | Plan Number |
|---|---|---|---|
| | | | |
| **Group Number (IMO Only)** | | **Customer Code (Optional)** | |
| | | | |

**Employer Group Information (To Be Completed by Employer)**

**Employer Name – Full Name of Business or Organization**

**Employer Address (Street, City, State, ZIP Code) – Primary Location of Business or Organization**

### A. Type of Activity – Employee Completes Sections A – E. *Please Print Clearly.*

**Enrollment** – *Check one.*
- ☐ New Enrollee/Subscriber
  - **Effective Date:** ____/____/____
  - **Date of Hire:** ____/____/____
- ☐ Rehire/Reinstatement
  - **Date of Rehire/ Reinstatement** ____/____/____

**Change** – *Check all that apply.*
- ☐ Add Spouse
- ☐ Add Dependent Child
- ☐ Name Change
- ☐ Other _____
- ☐ Control/Suffix/Acct/Plan: _____

**Date of Event:** ____/____/____

**Reason:** _____

**Remove or Terminate** – *Check all that apply.*
- ☐ Remove Spouse
- ☐ Remove Dependent Child
- ☐ Employee Withdrawal/ Termination
- ☐ Cancel Coverage

**Effective Date:** ____/____/____

**Reason:** _____

**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 Administration

**Date of Loss of Coverage:** ____/____/____

**Date of Qualifying Event:** ____/____/____

**Continuation of Coverage Expiration Date:** ____/____/____

### B. Employee Information

| Social Security Number | Last Name, First Name, M.I. | | Home Telephone | Work Telephone |
|---|---|---|---|---|
| Employee Status ☐ Active ☐ Retired | Home Address | Apt. No. | City, State | ZIP Code |

**Beneficiary & Earnings information -** Do not complete if Aetna Life Insurance coverage is not offered by your Employer.

| Beneficiary Designation – **Full Beneficiary Name** (First, Middle, Last) If more than one beneficiary, use Special Remarks (Section D). | | **Earnings** |
|---|---|---|
| Social Security Number of Beneficiary | Relationship to Employee | ☐ Annually $ _____<br>☐ Weekly $ _____<br>☐ Insurance Amount $ _____<br>☐ Supplemental Life $ _____<br>☐ AD&D Amount $ _____ |

### C. Plan Options – Your selection must be offered by your employer.

***Check One:***

- ☐ Aetna Open Access® Managed Choice (OAMC)
- ☐ Aetna Open Access® Managed Choice (OAMC) High Deductible Health Plan (HDHP)
- ☐ Aetna Open Access® Managed Choice (OAMC) Health Reimbursement Arrangement (HRA)
- ☐ Open Access® Managed Choice Aetna Whole Health (AWH) **-** Puget Sound (King, Pierce and Snohomish Counties)
- ☐ Aetna Open Choice® PPO
- ☐ Other: _____

While the Federal Patient Protection and Affordable Care Act generally 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.

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

☐ **Check this box if you are refusing coverage for your dependents.** **** Provide details for "Yes*" responses below.***

| (A)dd (C)hange ____ (R)emove | 1. **Employee Name** - Last, First, M.I. | Relation. Code | Sex (M/F) | **Birthdate** (MM/DD/YYYY) |
|---|---|---|---|---|
| | | **Self** | | / / |

| **Social Security Number** | Other Medical Coverage | Other Rx Drug Coverage | Handicapped | Primary Medical Office ID Number | Current Patient |
|---|---|---|---|---|---|
| | **Yes*** ☐ | **Yes*** ☐ | **N/A** | | **Yes** ☐ |

| (A)dd (C)hange ____ (R)emove | 2. **Spouse Name** - Last, First, M.I. (Explain difference in last name in Special Remarks.) | Relation. Code | Sex (M/F) | **Birthdate** (MM/DD/YYYY) |
|---|---|---|---|---|
| | | | | / / |

| **Social Security Number** (if dependent has no SSN, write "None") | Other Medical Coverage | Other Rx Drug Coverage | Handicapped | Primary Medical Office ID Number | Current Patient |
|---|---|---|---|---|---|
| | **Yes*** ☐ | **Yes*** ☐ | **Yes** ☐ | | **Yes** ☐ |

| (A)dd (C)hange ____ (R)emove | 3. **Child Name** - Last, First, M.I. (Explain difference in last name in Special Remarks.) | Relation. Code | Sex (M/F) | **Birthdate** (MM/DD/YYYY) |
|---|---|---|---|---|
| | | | | / / |

| **Social Security Number** (if dependent has no SSN, write "None") | Other Medical Coverage | Other Rx Drug Coverage | Handicapped | Primary Medical Office ID Number | Current Patient |
|---|---|---|---|---|---|
| | **Yes*** ☐ | **Yes*** ☐ | **Yes** ☐ | | **Yes** ☐ |

| (A)dd (C)hange ____ (R)emove | 4. **Child Name** - Last, First, M.I. (Explain difference in last name in Special Remarks.) | Relation. Code | Sex (M/F) | **Birthdate** (MM/DD/YYYY) |
|---|---|---|---|---|
| | | | | / / |

| **Social Security Number** (if dependent has no SSN, write "None") | Other Medical Coverage | Other Rx Drug Coverage | Handicapped | Primary Medical Office ID Number | Current Patient |
|---|---|---|---|---|---|
| | **Yes*** ☐ | **Yes*** ☐ | **Yes** ☐ | | **Yes** ☐ |

| (A)dd (C)hange ____ (R)emove | 5. **Child Name** - Last, First, M.I. (Explain difference in last name in Special Remarks.) | Relation. Code | Sex (M/F) | **Birthdate** (MM/DD/YYYY) |
|---|---|---|---|---|
| | | | | / / |

| **Social Security Number** (if dependent has no SSN, write "None") | Other Medical Coverage | Other Rx Drug Coverage | Handicapped | Primary Medical Office ID Number | Current Patient |
|---|---|---|---|---|---|
| | **Yes*** ☐ | **Yes*** ☐ | **Yes** ☐ | | **Yes** ☐ |

| (A)dd (C)hange ____ (R)emove | 6. **Child Name** - Last, First, M.I. (Explain difference in last name in Special Remarks.) | Relation. Code | Sex (M/F) | **Birthdate** (MM/DD/YYYY) |
|---|---|---|---|---|
| | | | | / / |

| **Social Security Number** (if dependent has no SSN, write "None") | Other Medical Coverage | Other Rx Drug Coverage | Handicapped | Primary Medical Office ID Number | Current Patient |
|---|---|---|---|---|---|
| | **Yes*** ☐ | **Yes*** ☐ | **Yes** ☐ | | **Yes** ☐ |

**1.** If "Yes" to **Other Medical Coverage** above, provide effective dates, name & policy number of insurance carrier, HMO, or other source & your **Member Identification Number**.

**2.** If "Yes" to **Other Rx Drug Coverage** above, provide effective dates, name & policy number of insurance carrier, HMO, or other source & your **Member Identification Number**.

**3.** Does any dependent listed above live at a different address than the employee? ☐ Yes ☐ No If "Yes," who & what address?

**Special Remarks**:

**E. Race/Ethnicity - Optional** (This information is designed for the purpose of data collection & will not be used for determining eligibility, rating or claim payment.)

| | | | |
|---|---|---|---|
| **Employee 1.** | ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____ | **Child 4.** | ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____ |
| **Spouse 2.** | ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____ | **Child 5.** | ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____ |
| **Child 3.** | ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____ | **Child 6.** | ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____ |

## Conditions of Enrollment

### Applicant Acknowledgments and Agreements

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 underwritten or administered by Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156 (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. 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.
4. I understand and agree that, with the exception of Aetna Rx Home Delivery® and Aetna Specialty Pharmacy®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, and Aetna Specialty Pharmacy, LLC, are subsidiaries 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.

**If you wish to receive documents electronically, please refer to Aetna Navigator® at http://www.aetna.com/individuals-families/aetna-navigator.html.**

## Employee Signature

I certify that all information supplied in this form is true and complete to the best of my knowledge and belief. I have read and agree to the Conditions of Enrollment on this Employee Enrollment/Change Request form.

**Misrepresentation:** 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.

| ***Employee Signature*** *- Required* | ***Date (Month/Day/Year)*** | ***Employee E-mail Address*** | ***Primary Language Spoken*** |
|---|---|---|---|
| **X** | / / | | |

## Employer Verification (To Be Completed by Employer)

| ***Employer Signature*** *- Required* | ***Title*** | ***Date (Month/Day/Year)*** |
|---|---|---|
| **X** | | / / |

## Instructions

### Employer

- Complete the **Employer Group Information** at the top of Page 1.
- Complete the **Employer Verification** below the Employee signature on Page 3. Employer must sign & date the Enrollment/Change Request for new enrollments or coverage changes to be processed.

**Employee – Complete Sections A – E.** Additional dependent and/or other information may be provided on a separate sheet. All attachments must be signed and dated.

**Section A – Type of Activity:**

- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.
- Provide Effective Date(s) & 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 Options:** Your selection must be 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 names(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, & Social Security Number for each individual.
  - *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) currently have **Other Medical Coverage**, check the "Yes" box(es) and provide beginning & ending effective dates, name & policy number of insurance carrier, HMO or other source & 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 & ending effective dates, name & policy number of insurance carrier, HMO or other source & 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 & financially dependent, check "Yes" & provide proof of handicapped status from the attending physician.
- 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.

**Section E – Race/Ethnicity (Optional):** Check the appropriate Race/Ethnicity code for each individual. If your Race/Ethnicity is "Other," print the Race/Ethnicity for each individual in the space provided.

**Conditions of Enrollment/Misrepresentation – Employee Signature:** Employee must sign & date the Enrollment/Change Request for new enrollments or coverage changes to be processed.