aetna® Arizona Employee Enrollment/Change Form
(For groups with 2 to 50 employees)

Life, Accidental Death & Personal Loss Coverage (AD&D Ultra®), Disability, Aetna Vision℠ Preferred plans, Aetna PPO plans, Aetna HDHP-HSA plans, Aetna Savings Plus plans, and Aetna Indemnity plans are underwritten by Aetna Life Insurance Company. Aetna HMO plans and Aetna HNO plans are underwritten by Aetna Health Inc., Aetna Life Insurance Company and/or Aetna Health Insurance Company. Aetna Dental plans are underwritten by Aetna Life Insurance Company. For Vision coverage, certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care, LLC ("EyeMed").

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 G.** Please use only black ink to complete this form.

Group number
86830557
Aetna member ID number (if available)

Company name: Arizona Comfort Zone

Effective date / **Date of hire**	☐ 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 (must be the actual location for rates and network availability)	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

Salary (if enrolling for life or disability coverage) $ _____ ☐ Hourly ☐ Weekly ☐ Monthly

Number of hours worked a week

Check one: ☐ Full time ☐ Part time ☐ 1099 ☐ Retiree ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union

B. Coverage selection – *Please print clearly. (Top boxes for employer and Aetna use only.)*

Control/Group number	**Suffix**	**Account**	**Plan number**	**Class code**

1. Medical:

☑ **Extended Network PPO** – Plan option $6850 deductible
☐ **Extended Network HNO** – Plan option _____
☐ **Extended Network HMO** – Plan option _____
☐ **Banner Health Network** – Plan option _____
☐ **Arizona Care Network** – Plan option _____
☐ **Savings Plus** – Plan option _____
☐ **Summit** – Plan option _____
☐ **HSA/HDHP Compatible** – Plan option _____
☐ **Indemnity** (only available if PPO networks are not available) – Plan option _____

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B. Coverage selection *(Continued)*

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: _____

For FOC, choose: ☐ DMO® or ☐ PPO

Voluntary plans – Plan number _____ Plan name: _____

For 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

Control/Group number	Suffix	Account	Plan number

3. Vision

Aetna Vision℠ Preferred ☐ Yes ☑ No

Control/Group number	Suffix	Account	Plan number

4. Life and disability ☐ Yes ☑ No *Check all that apply.*

☐ Basic Life / AD&D Ultra® ☐ Short Term Disability ☐ Life and Disability Packaged Plan

☐ Optional dependent term life (for groups with 10 to 50 eligible employees)

C. Life Health Questionnaire for Employees who are requesting Basic Life benefits greater than the Guaranteed Issue Level) – Please complete the Uniform Employee Health Status Questionnaire, which can be found at www.id.state.az.us/consumerbusiness.html#health.

D. Individuals covered – ***List individuals for whom you are enrolling or adding, changing or removing coverage. Add more sheets if needed.***

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. Enter domestic partner only if your employer has elected that coverage.

1	☐ Add ☐ Change ☐ Remove	**Employee name** (Last, first, middle initial)	Sex (M/F)
Birthdate (MM/DD/YYYY) / /	Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated	Choosing coverage for : ☐ Medical ☐ Dental ☐ Vision ☐ STD ☐ Life / AD&D Ultra® ☐ Life & Disability Packaged Plan	
Primary care physician (PCP) provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes

2	☐ Add ☐ Change ☐ Remove	**Name** (Last, first, middle initial) ☐ **Spouse** ☐ **Domestic Partner**	Sex (M/F)	Social Security number
Birth date (MM/DD/YYYY) / /	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision ☐ Life / AD&D Ultra®			
PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes	

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 ☐ Life / AD&D Ultra®		
PCP provider ID number	Current patient ☐ Yes	Dental provider office ID number	Current patient ☐ Yes	

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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 ☐ Life / AD&D Ultra®	
PCP provider ID number		Current patient ☐ Yes		Dental provider office ID number	Current patient ☐ Yes
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 ☐ Life / AD&D Ultra®	
PCP provider ID number		Current patient ☐ Yes		Dental provider office ID number	Current patient ☐ Yes
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 ☐ Life / AD&D Ultra®	
PCP provider ID number		Current patient ☐ Yes		Dental provider office ID number	Current patient ☐ Yes

E. Dependent information

List any dependent in Section **D** with a different last name or 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

G. Declining coverage – *Check all that apply.*

I understand I am eligible to apply for this coverage through my employer; however, I am declining the coverage I checked below:

☐ Employee:	☐ Medical ☐ Dental ☐ Vision ☐ STD ☐ Life / AD&D Ultra® ☐ Life & Disability Packaged Plan	
☐ Spouse / domestic partner:	☐ Medical ☐ Dental ☐ Vision ☐ Life / AD&D Ultra®	
☐ Child(ren):	☐ Medical ☐ Dental ☐ Vision ☐ Life / AD&D Ultra®	

Reason for declining coverage

- ☐ Parental group coverage
- ☐ Spouse / domestic partner group coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Retiree coverage
- ☐ COBRA coverage
- ☐ Insurance through another job
- ☐ Indian Health Services
- ☐ TRICARE / Military coverage
- ☐ Individual coverage – On Exchange
- ☐ Individual coverage – Off Exchange
- ☐ Another group plan provided by my employer
- ☐ Do not want
- ☐ Other _____

I certify I have been given the right to apply for this coverage; however, I am declining coverage as noted above. 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.

Please sign here ONLY if you are declining coverage for yourself and / or dependent(s). ***Date (Month/Day/Year)***

☐ I am declining coverage. **Employee signature:** X

Please PRINT employee 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 the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
   - Aetna HMO and HNO plans: Aetna Health Inc., Aetna Life Insurance Company and/or Aetna Health Insurance Company
   - Aetna PPO, Aetna HDHP-HSA, Aetna Savings Plus, and Aetna Indemnity plans: Aetna Life Insurance Company
   - Aetna Vision℠ Preferred plans: Aetna Life Insurance Company; certain claims adjudication and other administrative services are provided by First American Administrators, Inc. (an affiliate of EyeMed Vision Care, LLC) and/or its affiliates
   - Dental, life, disability and other health coverages: Aetna Life Insurance Company.
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.

   For life coverage: I understand that the effective date of insurance for myself or for any of my dependents is subject to my being active at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the benefit plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent. For Dependent Life, dependent children are eligible from birth up to their 26th birthday.

   For disability coverage: I understand that the effective date of my insurance is subject to my being active at work on that date. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent.
3. I understand and agree that this Enrollment/Change Form 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"), including pharmacies or pharmacy database benefit managers to give to Aetna or its agent information concerning the medical history, prescription utilization history, services or treatment provided to anyone listed on this Enrollment/Change Form, including those involving mental health and substance abuse. 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/domestic partner 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 is valid for term of the coverage and so long thereafter as allowed by law. I understand that I am entitled, as is any authorized representative that I may designate, to receive a copy of this authorization upon request and that a photocopy is as valid as the original. 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. 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 changes in policy benefits shall remain valid for thirty (30) months from the date signed. Authorization 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 agent 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 Arizona 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.
5. 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.
6. 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.
7. I understand and agree that, with certain exceptions described in the plan documents, HMO and DMO® 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, primary care dentist, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.

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 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 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.

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)***

Designation of beneficiary – Carefully review Conditions and instructions for designation of beneficiary below.

The Group Policy grants the member the authority to designate a beneficiary. A beneficiary is the person or entity who will receive the benefit payment. A primary beneficiary will be the first to receive the benefit. A contingent beneficiary will only receive the benefit payment if the primary beneficiary(ies) predeceases the insured or is otherwise barred by a state law and/or a legally binding document addressing benefit payments. The employee is automatically the primary beneficiary for dependent life and accidental death and personal loss coverage (AD&D Ultra®) benefits.

Beneficiary for:	**Full name(s) or entity (trust or estate)**	**Date of birth**	**Social Security number / tax ID number**	**Address** (number, street, apt. number, city, state, ZIP code)	**Phone**	**Relationship to employee**	**% of benefit** (must equal 100%)
Life Primary							
Life Contingent							

SPOUSAL CONSENT FOR COMMUNITY PROPERTY STATES ONLY – see Conditions and instructions for designation of beneficiary section below.

Please note that an employee is under no obligation to complete the spousal consent section on this form.

I am aware that my spouse, the employee named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse signature _____ **Date** _____

Conditions and instructions for designation of beneficiary

Conditions for designation of beneficiary

- **Please note:** The Group Policy grants only the member the authority to designate a beneficiary. If you do not name a beneficiary, payment will be made to your survivors as described in the Group Policy's beneficiary provision. You should execute the Designation of beneficiary section of this form to ensure payment is made to the person you want.
- Unless otherwise expressly provided in the Designation of beneficiary section of this form, if any named primary beneficiary predeceases you, the life proceeds shall be paid equally to the remaining named primary beneficiary or beneficiaries. All primary beneficiaries must predecease you before the life proceeds will be paid to any contingent beneficiaries.
- If this Designation of beneficiary provides for payment to a trustee under a trust agreement, Aetna Life Insurance Company (Aetna) shall not be obliged to know or be liable under the terms and conditions of the trust agreement. If your beneficiary is a minor at the time of your death, Aetna may require the court to appoint a guardian to receive the life proceeds for the minor.
- Aetna will be fully discharged of its duties when payment is made. Aetna is not responsible for how the payment is used.
- If you live in one of the following community property states – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin – your spouse may have a legal claim for a portion of the life insurance benefit under state law. If you name someone other than your spouse as beneficiary, payment of the death benefit may be delayed until your spouse's claim is resolved.

Instructions for designation of beneficiary

If these instructions do not answer all your questions, please contact your plan sponsor for assistance.

- If you make a mistake in completing this form, line out the erroneous information, add the correct information and initial the correction. **The printed material on this form should not be deleted or altered in any way.**
- **In all cases**, the relationship of the beneficiary, the beneficiary's Social Security number, address and phone number should be included with the beneficiary designations.
- **Dollars and cents should not be specified**.
- If a minor child is named beneficiary, the child will not receive the benefits until age of majority.
- If a trustee is named beneficiary, show the exact name of the trust, date of the trust agreement, and the name and address of the trustee. **For example**, The John J. Smith Revocable Life Insurance Trust, dated January 1, 1994. John Smith, Trustee, 123 Apple Lane, Hartford, CT 06006.