aetna®

Employee Enrollment/Change Form

Member ID Number (if available)

Employer Name

INSTRUCTIONS: You, the employee, must complete 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. If waiving coverage, please complete Sections A and B.

Effective Date

Date of Hire

- ☐ New Hire
- ☐ Rehire/Reinstatement
- ☐ New Group Enrollment
- ☐ Late Enrollment
- ☐ Waiver
- ☐ Open Enrollment
- ☐ Other: _____

- ☐ Change of coverage
- ☐ Add Spouse
- ☐ Add Civil Union (state specific)
- ☐ Add Domestic Partner (state specific)
- ☐ Add Dependent Child
- ☐ Name Change
- ☐ Other _____

- ☐ Employee Termination
- ☐ Remove Spouse
- ☐ Remove Civil Union (state specific)
- ☐ Remove Domestic Partner (state specific)
- ☐ Remove Dependent Child
- ☐ Cancel Coverage

☐ COBRA ☐ State Continuation for: ☐ Employee ☐ Dependent
Length of Continuation: ☐ 18 ☐ 36 ☐ Other _____

Original Qualifying Event Date _____ Qualifying Event _____

Reason: _____

A. Employee Information

Social Security Number	Last Name, First Name, M.I.	Job Title	Home Telephone	Primary Language Spoken (Optional)	
Home Address		Apt. No.		City, State	ZIP Code
Work Address		City, State		ZIP Code	Work Telephone

Salary $ ☐ Hourly ☐ Weekly ☐ Monthly

Number of Hours Worked Per Week

Check One: ☐ Full-Time ☐ Part-Time ☐ 1099 ☐ Retired ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union

Email address (if we may correspond with you via email)

B. Medical Coverage Selection – *Check plan desired.*

☐ PPO Plan Option _____ ☐ POS Plan Option _____ ☐ HMO Plan Option _____ ☐ Indemnity Plan Option _____

C. Dependent Information - *List any dependent living at another address.*

Name:	Address:	Name:	Address:

D. Other Medical Coverage - *List any individuals who will have other health insurance at the same time as this coverage.*

Name of Person	Carrier Name	Name of Person	Carrier Name

E. Medicare Coverage - *List individuals covered by Medicare.*

Name of Person	Medicare Part A	Medicare Part B	Medicare Part D	Over Age 65	Disability	End-Stage Renal Disease Effective Date
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

F. Decline/Waive - *To be completed if medical and/or dental coverage is declined or refused by an eligible employee and/or their eligible family members.*

Medical Coverage Declined for:
- ☐ Myself
- ☐ Spouse/Civil Union/Domestic Partner
- ☐ Children

Reason for Declining Coverage
- ☐ Parental Coverage
- ☐ COBRA coverage
- ☐ Retiree coverage
- ☐ Tricare
- ☐ Medicare
- ☐ Medicaid
- ☐ VA coverage
- ☐ Spousal/Civil Union/Domestic Partner group coverage
- ☐ Another group plan provided by my employer
- ☐ Insurance through another job
- ☐ Individual coverage – On or Off Exchange
- ☐ Do not want
- ☐ 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 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 ONLY if you are declining coverage for yourself or dependent(s).

X Employee Signature

Date (Month/Day/Year)

G. Individuals Enrolling - *List individuals enrolling or adding/changing/removing coverage. If more space is needed to provide information for additional dependents check here ☐ and use a separate sheet of paper.*

(A)dd (C)hange (R)emove	Name (Last, First, M.I.)	Sex M/F	Social Security Number	Birthdate (MM/DD/YYYY)	Height	Weight	Tobacco Use and Amount used per day	Currently Taking Prescription Medication(s)	Incapacitated
	Employee 1.						☐ Cigarette ☐ Other _____ Amount:	☐ Yes ☐ No	Yes ☐
	☐ Spouse ☐ Domestic Partner 2.						☐ Cigarette ☐ Other _____ Amount:	☐ Yes ☐ No	Yes ☐
	☐ Child ☐ Stepchild ☐ Other 3.						☐ Cigarette ☐ Other _____ Amount:	☐ Yes ☐ No	Yes ☐
	☐ Child ☐ Stepchild ☐ Other 4.						☐ Cigarette ☐ Other _____ Amount:	☐ Yes ☐ No	Yes ☐

H. Health Questionnaire – *Complete for all individuals enrolling for coverage.*

Have you or anyone applying for coverage consulted with or been examined, diagnosed, or treated by any health care professional during the last (10) years for any illness, injury or health condition in any of the categories listed below? If "Yes," please check the box that most appropriately describes the condition(s), **circle** the applicable condition(s), and explain fully below.

1. **Bone / Muscle**: Arthritis, Back/Neck/Spine problems, Joint disorders, Joint replacement, Herniated disc, Other. **Brain / Nervous:** Epilepsy (Seizures), Paralysis/Paresis, Pituitary disorder, Stroke, Other. **Heart / Circulatory:** Chest pain, Congestive Heart Failure, Heart Attack, Heart Disease, Hemophilia, High Blood Pressure, Sickle Cell Disease, Other. **Immune:** AIDS/HIV, Connective Tissue Disorder, Immunodeficiency, Systemic or Discoid Lupus, Other. **Intestinal / Endocrine**: Adrenal disorder, Cirrhosis, Crohn's, Diabetes Type I or Type II, Digestive disorder, GERD (reflux), Hepatitis B, C, or other, Liver or Pancreas disorder, Stomach ulcer, Ulcerative Colitis, Other. **Lung / Respiratory**: COPD, Emphysema, Other. **Substance Abuse**: Alcohol or Drug Abuse. **Reproductive**: Infertility, Other. **Transplant:** Organ or Bone Marrow Transplant (planned, recommended or already performed). **Tumor**: Fibroids (location), Other. **Urinary:** Bladder disorder, Dialysis, Kidney failure, Kidney stones, Other. **Other:** Birth defect/Congenital abnormality, Growth disorder (including Dwarfism or receiving growth hormones), Paralysis or Paresis, Prosthesis, Other.	☐ Yes ☐ No
2. Cancer - Type:_____ Stage _____ **Check applicable boxes**: ☐ Surgery- date _____ ☐ Chemo- end date _____ ☐ Radiation- end date _____	☐ Yes ☐ No
3. Is any female currently pregnant? If yes, provide due date _____ **Check applicable boxes**: ☐ C section planned ☐ Multiple Births Expected (# _____) ☐ Complications: ☐ Past or ☐ Present (if current complications, give details per below)	☐ Yes ☐ No
4. During the last 24 months, has anyone applying for coverage been hospitalized? (Provide full details per below.)	☐ Yes ☐ No
5. Is anyone applying for coverage been advised they need future hospitalization or have surgical procedures been planned, discussed, or recommended? Provide full details per below.	☐ Yes ☐ No
6. Does anyone applying for coverage taking any prescription medications? (Provide full details below to include medication name and condition for which the medication is needed.)	☐ Yes ☐ No
7. Does anyone applying for coverage have any other medical condition which has not yet been disclosed? Provide full details below.	☐ Yes ☐ No

IF YOU ANSWERED "YES" TO ANY QUESTIONS, PLEASE EXPLAIN BELOW. (If additional space is required, please attach a separate sheet and the applicant needs to sign/date sheet.)

Question Number	Enrollee Name	Conditions, Diagnosis & Treatments	Start Date	End Date	Medications (Include name and oral, injectable, or infusion)	Dosage	Is Treatment ongoing? If YES, provide details of any current OR future treatment.

Conditions of Enrollment

I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and the employer application have been accepted and approved by Aetna. Even if this enrollment form is approved, any intentional and material misstatements or omissions that amount to fraud, or which would have affected the carrier's rating, offering or issuing of coverage impacted, may result in future claims being denied and the policy or my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes. Failure to disclose all health information encompassed by the questionnaire will be deemed to be material omissions for rating purposes.

I understand and agree that this enrollment 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 and pharmacy database benefit managers to give 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, 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. 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.

I certify that all information and statements furnished by me are true and complete to the best of my knowledge. I am duly authorized to execute this Statement of Health. I am employed by the employer on page 1 and working full time for this employer.

I understand that any person who knowingly and with intent to defraud 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.

Employee Signature	Date