



Enrollment/Change Request

Aetna Life Insurance Company

TO COMPLY WITH CALIFORNIA LAW, WHEREVER THE TERM "SPOUSE" APPEARS, IT SHALL INCLUDE A DOMESTIC PARTNER.

Employer Group Information: (To Be Completed by Employer)	Employer Name - Full Name of Business or Organization	Control	Suffix	Account	Plan Number
	Employer Address (Street, City, State, ZIP Code) - Primary Location of Business or Organization	Group Number (IMO Only)	Customer Code (Optional)		

A. Type of Activity - Employee Completes Sections A - E. Please Print Clearly.

Instructions: Refer to the instructions on the back before completing this form. You, the employee, 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.	Enrollment - Check one. <input type="checkbox"/> New Enrollee/Subscriber <input type="checkbox"/> Rehire/Reinstatement	Change - Check all that apply. <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Other <input type="checkbox"/> Control/Suffix/Acct/Plan	Remove or Terminate - Check all that apply. <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Remove Dependent Child <input type="checkbox"/> Employee Withdrawal/Termination <input type="checkbox"/> Cancel Coverage	Continuation of Coverage, i.e., COBRA, State - Not all options are available. Contact Employer for available options. Coverage For: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation (months): <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____ <input type="checkbox"/> 29 - Attach disability determination from the Social Security Admin.
	Effective Date: / / Date of Hire: / /	Date of Rehire/Reinstatement: / / Reason: _____	Date of Event: / / Reason: _____	Effective Date: / / Reason: _____

B. Employee Information

Social Security Number	Last Name, First Name, M.I.	Home Telephone () () ()	Work Telephone () () ()
Employee Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Home Address	Apt. No.	City, State
Beneficiary Designation - Full Beneficiary Name (First, Middle, Last) If more than one beneficiary, use Special Remarks (Section D).	Social Security Number of Beneficiary	Relationship to Employee	Earnings <input type="checkbox"/> Annually \$ _____ <input type="checkbox"/> Weekly \$ _____
			<input type="checkbox"/> Insurance Amount \$ _____ <input type="checkbox"/> Supplemental Life \$ _____ <input type="checkbox"/> AD&D Amount \$ _____

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

Check One:

<input type="checkbox"/> Aetna Choice™ POS II	<input type="checkbox"/> Managed Choice® POS
<input type="checkbox"/> Aetna HealthFund™	<input type="checkbox"/> Open Choice® PPO
<input type="checkbox"/> Aetna Open Access™ Elect Choice	<input type="checkbox"/> Traditional Choice®
<input type="checkbox"/> Aetna Open Access™ Managed Choice	<input type="checkbox"/> Aexcel SM
<input type="checkbox"/> Elect Choice® EPO	<input type="checkbox"/> Aexcel SM Plus
	<input type="checkbox"/> Other _____

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

Attach sheet to list additional children. * Provide details for "Yes" responses below. Check this box if you are refusing coverage for your dependents.

(A)dd (C)hange (R)emove	Name (First, Middle Initial, Last) (Explain difference in last names in Special Remarks.)	Relation. Code	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Prior Insur. Plan	Other Medical Coverage	Other Rx Drug Coverage	Handi- capped	Student	Primary Medical Office ID Number	Current Patient	Race/Ethnicity - Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)
		Self	<input type="checkbox"/> <input type="checkbox"/>	/ /		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes N/A	Yes N/A		<input type="checkbox"/>	Using the KEY below, please identify the Race/Ethnicity code for each individual. KEY: 01 - White 02 - African American or Black 03 - Hispanic or Latino 04 - Asian 05 - Other (Provide race/ethnicity in "Other" column at left)
			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
			<input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	

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

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

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

Special Remarks

E. Employee Signature

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of this application. **Arbitration: Any dispute arising from or related to Health Plan membership will be determined by submission to binding arbitration, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The agreement to arbitrate includes, but is not limited to, disputes involving alleged professional liability or medical malpractice, that is, whether any medical services covered by this Agreement were unnecessary or were unauthorized or were improperly, negligently or incompetently rendered. The Health Plan agreement also limits certain remedies and may limit the award of punitive damages. See the Evidence of Coverage for further information. I understand that I am giving up the constitutional right to have disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration. This means that members will not be able to try their case in court. I further understand that the agreement contains limitations on certain remedies and that members cannot recover punitive damages.**

Employee Signature - Required X	Date: / /	E-Mail Address	Primary Language Spoken
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F. Employer Verification (To Be Completed by Employer)

Employer Signature - Required X
Title
Date: / /

Instructions

Employer

- Complete the **Employer Group Information** at the top of the form.
- Complete **Section F - Employer Verification** in the lower right corner of the form.
 - Employer must complete this section for all new enrollments or coverage changes.
 - Employer must sign and date the Enrollment/Change Request in order for it to be processed.

Employee - Complete Sections A - E.

Section A - Type of Activity:

- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.
- Provide Effective Date(s) and 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: Select only an option 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 name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
 - 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) were covered under your employer's or other **Prior Insurance Plan** or currently have **Other Medical Coverage**, check the "Yes" box(es) and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **Member Identification Number** 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 and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **Member Identification Number** 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 and financially dependent, check "Yes" and provide proof of handicapped status from the attending physician.
- If a dependent is a Student, check "Yes". Refer to your Summary Coverage for plan definitions. Aetna may request that you provide proof from the educational institution.
- 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.
- *Optional* - Using the KEY provided, please enter the Race/Ethnicity code for each individual. If your Race/Ethnicity is "Other," print the Race/Ethnicity for each individual in the space provided.

Section E - Employee Signature:

- Complete this section for all new enrollments or coverage changes.
- Employee must sign and date the Enrollment/Change Request in order for it to be processed.

Section F - Employer Verification:

- Employer must complete this section for all new enrollments or coverage changes.
- Employer must sign and date the Enrollment/Change Request in order for it to be processed.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, 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 (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, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary 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.

Misrepresentation

For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a 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.