Enrollment/Change Request
Aetna Health of California Inc.

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

Employer Group Information - To Be Completed by Employer:	Group Name	Group Number	Class Code

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
- ☐ New Enrollee/Subscriber
- Effective Date: / /
- Date of Hire: / /

Change - *Check all that apply.*
- ☐ Add Spouse
- ☐ Add Dependent Child
- ☐ Name Change
- ☐ Change Plan
- ☐ Other
- Date of Event: / /
- Reason

Remove or Terminate - *Check all that apply.*
- ☐ Remove Spouse
- ☐ Remove Dependent Child
- ☐ Employee Withdrawal/ Termination
- 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 Admin.
- Date of Loss of Coverage: / /
- Date of Qualifying Event: / /

B. Employee Information

Social Security Number	Last Name, First Name, M.I.		Home Telephone ( )
Home Address	Apt. No.	City, State	ZIP Code
Employer Name			Work Telephone ( )
Work Address		City, State	ZIP Code

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

Check One:
- ☐ HMO ☐ QPOS®
- ☐ Aetna HealthFund® HMO

Indicate Plan Name

Primary Copay:
- ☐ $5 ☐ $10
- ☐ $15 ☐ Other $ ______

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. ***Provide details for "Yes" responses below.*** Attach sheet to list additional children. Attach proof if full-time college student.

(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number (If dependent has no SSN, write "None")	Other Medical Coverage	Other Rx Drug Coverage	Handi-capped	Primary Office ID Number	Current Patient	Dentist Office ID Number (If applicable)	Current Patient	Race/Ethnicity - Code	Race/Ethnicity - Other
	Employee	☐ ☐	/ /		Yes* ☐	Yes* ☐	Yes N/A		Yes ☐		Yes ☐		
	Spouse	☐ ☐	/ /		☐	☐	☐		☐		☐		
	Child	☐ ☐	/ /		☐	☐	☐		☐		☐		
	Child	☐ ☐	/ /		☐	☐	☐		☐		☐		

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.)

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)

1. If "Yes" to **Other Medical Coverage** above, provide effective dates, name & policy number of insurance carrier, HMO, or other source and 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 and your **Member Identification Number.**
3. Does any dependent listed above live at a different address than the employee? ☐ Yes ☐ No If "Yes," who and what address?

   Explain the circumstances:
4. If any dependent's last name differs from yours, explain the circumstances.
5. Is your spouse employed? ☐ Yes ☐ No If "Yes," provide name and address of spouse's employer.

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.

If you have questions concerning the benefits provided by or excluded under this Agreement, contact a Member Services representative at 1-800-323-9930 before signing this form.

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. **CALIFORNIA HMO APPLICANTS: 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 the Group Agreement were *unnecessary or were unauthorized or were improperly, negligently or incompetently rendered.* This agreement also limits certain remedies and may limit the award of punitive damages. See Sections "Binding Arbitration" and "Limitations on Remedies" of 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*	Date	E-Mail Address	Primary Language Spoken
X	/ /		

F. Employer Verification (To Be Completed by Employer)

Employer Signature - *Required*
X
Title
Date / /

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Aetna prior to visiting a specialist or admission to a hospital.

Please make a copy for your records. **visit us at www.aetna.com**

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.

NOTE: Please provide any additional Dependent and/or other information on a separate sheet of paper and attach it to this form.

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.

Section C - Plan Options:

- Select only an option offered by your employer.
- Check one Plan Option box, indicate Plan Option Name (where applicable) and check *one* Primary Copay.

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.
- If a dependent is a full-time college student, you **must** attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits).
- If you or your dependent(s) have **Other Medical 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 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.
- Primary Medical Office ID Number/Primary Dental Office ID Number: Locate the office ID number for the primary care physician and/or dentist (if applicable) 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 the HMO, QPOS or Aetna HealthFund HMO plans coverage is underwritten or administered by Aetna Health of California Inc. (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 (Group Agreement, Evidence of Coverage, Schedule of Benefits, amendments, riders or endorsements) 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.
5. I understand and agree that, with certain exceptions described in the plan documents, HMO 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, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.

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.