



**D. Individuals Covered - List individuals for whom you are enrolling or adding/changing/removing coverage. Attach additional sheets if necessary.**

**NOTE:** While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

(Add/Change/Remove)	Last Name, First Name, M.I.	Sex M/F	Social Security Number	Birthdate MM DD YYYY	Disabled	Other Medical Coverage	Other Rx Drug Coverage	Out of Area	Primary Office ID Number (if applicable)		Current Patient
									NPI Number		
1. Employee					Yes N/A	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Office NPI		Yes <input type="checkbox"/>
2. Spouse/Civil Union/Domestic Partner					N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Office NPI		<input type="checkbox"/>
3. Child					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Office NPI		<input type="checkbox"/>
4. Child					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Office NPI		<input type="checkbox"/>

**E. 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.)**

Employee 1. <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latin - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	Child 3. <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latin - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____
Spouse/Civil Union/Domestic Partner 2. <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latin - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____	Child 4. <input type="checkbox"/> White - 01 <input type="checkbox"/> African American or Black - 02 <input type="checkbox"/> Hispanic or Latin - 03 <input type="checkbox"/> Asian - 04 <input type="checkbox"/> Other - 05 _____

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

Coverage Declined for:  Myself  Dependents  Spouse/Civil Union/Domestic Partner

Reason for Declining Coverage (If applicable, please attach front/back of your coverage ID card.):

Covered by Spouse's/Civil Union/Domestic Partner's group coverage - Carrier Name and ID Number \_\_\_\_\_

Enrolled in another Medical Plan - Carrier Name and ID: \_\_\_\_\_

Medicare  Covered by TRICARE or CHAMPVA  Other (Explain): \_\_\_\_\_

Spouse/Civil Union/Domestic Partner covered by employer's group medical coverage

Spouse/Civil Union/Domestic Partner covered by employer's group dental coverage

I was given the opportunity to enroll in the medical plan offered by my employer and underwritten by Aetna Health Inc. and Aetna Health Insurance Company; however, I refuse the above coverage(s). 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 or your dependent(s). Date (Month/Day/Year)

Employee Signature

**G. Dependent Information**

Does any dependent listed in Section D live at another address?  Yes  No  
If Yes, who and what address? \_\_\_\_\_

If any dependent's last name differs from yours, explain the circumstances. \_\_\_\_\_

**H. Other Medical Coverage**

If you have checked Yes to Other Medical or Rx Drug Coverage (Section C), provide name and policy number of carrier, HMO, or other source, a copy of the ID card, and start date of the coverage.

If enrolling your Spouse/Civil Union/Domestic Partner, are they employed?  Yes  No If Yes, provide name and address of Spouse's/Civil Union/Domestic Partner's employer. \_\_\_\_\_

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Medical
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

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

**I. Conditions of Enrollment**

**Applicant Acknowledgments and Agreements**

On behalf of myself and the dependents listed in Section D, I agree to or with the following:

- 1. a) I authorize the sources stated below to give to Aetna Health Inc. and/or Aetna Health Insurance Company or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer. Please note that a consumer report includes information regarding the enrollee's character, general reputation, personal characteristics, and mode of living. If you would like a copy of your consumer report obtained by Aetna, you may contact Member Services. Aetna will provide a copy of the report upon request.
- b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Aetna Health Inc. and/or Aetna Health Insurance Company has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
- c) I know that I have a right to receive a copy of the authorization if I request one.
- d) I agree that a photocopy of this authorization is as valid as the original.
- 2. I acknowledge by enrolling in an Aetna plan, coverage is provided by Aetna Health Inc. and/or Aetna Health Insurance Company in accordance with the contract.
- 3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Aetna Health Inc. and/or Aetna Health Insurance Company.
- 4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

**Misrepresentation**

- 5. Any person who includes any false or misleading information on an Enrollment/Change Request Form for a medical benefits plan is subject to criminal and civil penalties.

**J. Employee Signature**

I represent that all the information supplied in this application is true and complete to the best of my knowledge and belief. I hereby agree to the conditions of enrollment contained in this Enrollment/Change Request form. I authorize deductions from my earnings for any required contributions.

<i>Employee Signature - Required</i>	<i>Employee E-mail Address (optional)</i>	<i>Date (Month/Day/Year)</i>
X		

**K. Employer Verification - To be completed by Employer**

<i>Employer Signature - Required</i>	<i>Title</i>	<i>Date (Month/Day/Year)</i>
X		

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

Please make a copy for your records. Visit us at [www.aetna.com](http://www.aetna.com).

**NOTE: To Add, Change, or Remove coverage for dependents over the limiting age, but less than 31, Aetna form HINT Supplemental Enrollment Information Form, implementing P.L.2005,c.375, must be completed.**

## Instructions

### Employer

- Complete Section K - Employer Verification.
- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date this Enrollment/Change Request form in order for it to be processed.

### Employee – Complete Sections A – J

#### Section A – Type of Activity:

- Check boxes indicating reason(s) for submitting application.
- Employee must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date Section L of this Enrollment/Change Request form in order for it to be processed.

#### Section B – Medical Plan Options:

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

#### Section C – Employee Information: Complete all information in order for your application to be processed.

#### Section D – Individuals Covered:

- Do not complete this form for dependents over the limiting age, but less than 31; Aetna Form, HINT Supplemental Enrollment Information Form implementing P.L. 2005, c. 375, must be completed.
- 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 dependents, if applicable. Indicate Sex, Social Security Number and Birthdate for each individual listed.
- If dependent is disabled and being continued beyond the limiting age, attach proof of disability.
- If you or your dependent(s) have other Medical or Rx drug coverage, check off the Yes box(es) and complete Section I - Other/Previous Medical Coverage.
- From the appropriate provider directory, locate the 6-digit office ID number for the primary care physician and/or dentist (if applicable). Indicate office ID number selection(s) on the form.
- You may obtain each provider's NPI number by contacting the provider directly. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting the office directly.
- If you are a current patient, please check the "Current Patient" box.
- If you had previous coverage, please check the "Previous Coverage" box.

#### 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.

#### Section F – Declination/Waiver of Coverage: Complete this section if declining coverage for any eligible employee and/or their eligible family members. Employee must sign and date.

#### Section G – Dependent Information: Complete this section for all new enrollments or coverage changes.

#### Section H – Other Medical Coverage: Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, HMO, governmental coverage, a church plan or Medicare.

#### Section I – Conditions of Enrollment: Please read carefully.

#### Section J – Employee Signature:

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

#### Section K – Employer Verification:

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