



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	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/Reinstatement <input type="checkbox"/> New Group Enrollment <input type="checkbox"/> Late Enrollment	<input type="checkbox"/> Change of coverage <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Civil Union (state specific) <input type="checkbox"/> Add Domestic Partner (state specific) <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Other _____	<input type="checkbox"/> Employee Termination <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Remove Civil Union (state specific) <input type="checkbox"/> Remove Domestic Partner (state specific) <input type="checkbox"/> Remove Dependent Child <input type="checkbox"/> Cancel Coverage	<input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent Length of Continuation: <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____	Original Qualifying Event Date _____ Qualifying Event _____ Reason: _____
Date of Hire	<input type="checkbox"/> Waiver <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other: _____				

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 \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Number of Hours Worked Per Week	Check One <input type="checkbox"/> Full-Time <input type="checkbox"/> 1099 <input type="checkbox"/> Seasonal <input type="checkbox"/> COBRA <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> Temporary <input type="checkbox"/> 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:
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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
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/Civil Union/Domestic Partner <input type="checkbox"/> Children	Reason for Declining Coverage <input type="checkbox"/> Parental Coverage <input type="checkbox"/> Tricare <input type="checkbox"/> VA coverage <input type="checkbox"/> COBRA coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Spousal/Civil Union/Domestic Partner group coverage <input type="checkbox"/> Retiree coverage <input type="checkbox"/> Medicaid <input type="checkbox"/> Another group plan provided by my employer <input type="checkbox"/> Insurance through another job <input type="checkbox"/> Individual coverage – On or Off Exchange <input type="checkbox"/> Do not want <input type="checkbox"/> Other _____
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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)
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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